NAME ___________________________ BIRTHDATE___________AGE ______ TODAY'S DATE _______________

REASON FOR VISIT TODAY? ____

MEDICAL HISTORY

ALLERGIES OR DRUG REACTIONS: ____

MEDICATIONS (PLEASE LIST ALL MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS & SUPPLEMENTS TAKEN IN THE PAST 3 MONTHS):

NOW? ____

IN THE PAST THREE MONTHS? ____

HABITS:

	CURRENT USE	PAST USE
TOBACCO	________________________	________________
ALCOHOL	________________________	________________
"RECREATIONAL DRUGS"	________________________	________________
CAFFEINE	________________________	________________

ILLNESS: (PAST AND PRESENT)

CARDIAC? Y ____ N ____ THYROID? Y ____ N ____GLAUCOMA? Y ____ N ____
SEIZURES? Y ____ N ____ DIABETES? Y ____ N ____CHOLESTEROL PROBLEMS? Y____N_____
SURGERIES? ____
ACCIDENTS/HEAD INJURIES? ____
OTHER MEDICAL PROBLEMS? ____

FEMALES ONLY: ARE YOU PREGNANT? Y ____ N ____ PLANNING TO GET PREGNANT? Y ____ N _____

NUMBER OF PREGNANCIES _______________ MISCARRIAGES ________________ ABORTIONS ____________

PSYCHIATRIC HISTORY

PREVIOUS PSYCHIATRISTS/THERAPISTS: WHEN? ____

MEDICATIONS PRESCRIBED IN THE PAST? ____

PSYCHIATRIC HOSPITALIZATIONS: WHEN? ____________ WHY? ___________________________

WHEN? ____________ WHY? ________________________

FAMILY HISTORY

PSYCHIATRIC PROBLEMS (IN YOUR FAMILY): ____

SUICIDE ATTEMPTS IN YOUR FAMILY? ____

SEIZURES ____THYROID DISEASE ______________________________

DRUG PROBLEMS? ____________________________________ ALCOHOL ABUSE PROBLEMS? ______________

Please be aware all medicines may have the potential to cause problems in pregnancy or with the developing fetus.