

Adult Pre-Visit Questionnaire

Legal Name: _____ Preferred Name (if different): _____

Medication Allergies: _____ Marital Status: M D S W

Occupation: _____ Currently Employed: Y N

Pharmacy: _____

Medications:

Please list all medications currently taking, including dosages, and include over the counter medications taken regularly:

Past psychiatric medications:

Previous Psychiatric Treatment:

Previous Psychiatric Hospitalizations Y N If yes, _____

Suicide Attempts: Y N If yes, _____

Non-medication psychiatric treatments (including ECT, TMS, light therapy, etc.) Y N If yes, _____

Previous or current self-harming behaviors (i.e. cutting, etc.)? Y N If yes, please list method and frequency

Medical History:

Current/Chronic Illness or Surgeries: Y N If yes,

Head Injuries/Seizures: Y N If yes,

Do you have a medical marijuana card? Y N If yes, please list associated diagnosis: _____

Date of last routine physical exam: _____

Female Only: Last period: _____ Birth control: Y N If yes, _____

Habits:

Tobacco: _____ppd: _____ years: _____ Alcohol current: _____ Past: _____

Caffeine _____ cups coffee/day _____ colas/day _____ glasses of tea/day

Substance Use:

Please circle: None Past Present

If yes, please list substance type and amount/frequency of use:

Family History:

Please list any relatives with known or suspected **medical or psychiatric problems, attempted or completed suicides**, or history of **drug or alcohol abuse**.

Social History:

Who lives at home with you (name, age, relationship to you, occupation)?

Sexual Orientation? _____

Describe your current relationship

What are your favorite hobbies?

Level of Education:

Any stressful events in your childhood?

Abuse: Physical/Sexual/Emotional Y N If yes,

Legal Issues (i.e. DWI, jail/prison time, etc.): Y N If yes,

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Medical Review of Systems

Check next to any symptoms you have experienced since LAST VISIT/recently, Name: _____

or for which you have concerns about. Date: _____

BP _____ / _____ p _____ Ht _____ Wt _____

General	
<input type="checkbox"/>	Recent unexpected weight loss
<input type="checkbox"/>	Chronic fatigue
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Lack of regular exercise
<input type="checkbox"/>	Overweight

Gastrointestinal	
<input type="checkbox"/>	Recent loss of appetite
<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	Heartburn/gastritis
<input type="checkbox"/>	Persistent nausea/vomiting
<input type="checkbox"/>	Chronic abdominal pain
<input type="checkbox"/>	Gall bladder trouble
<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Change in appearance of stool
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Bloody or very dark stools
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Hernia

Integumentary	
<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Skin moles – black or changing
<input type="checkbox"/>	Breast mass
<input type="checkbox"/>	Nipple discharge

Hematologic/Lymphatic	
<input type="checkbox"/>	Excessive bruising
<input type="checkbox"/>	Swollen glands in neck, armpit, or groin
<input type="checkbox"/>	Unexplained fever, chills, night sweats

Eyes	
<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	Double vision
<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Frequent eye infections
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Cataracts

Neurologic	
<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	Tremor/hand shaking
<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	Numbness/tingling
<input type="checkbox"/>	Seizures/convulsions
<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	Excessive daytime sleeping
<input type="checkbox"/>	Memory loss

Allergic/Immunologic	
<input type="checkbox"/>	Hay fever/allergies
<input type="checkbox"/>	Acquiring many infections
<input type="checkbox"/>	Desire HIV discussion

Ears, Nose, Mouth	
<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	Ringing in ears
<input type="checkbox"/>	Frequent ear infections
<input type="checkbox"/>	Frequent nose bleeds
<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	Frequent sore throat
<input type="checkbox"/>	Prolonged hoarseness
<input type="checkbox"/>	Tooth or jaw pain

Genito-Urinary	
<input type="checkbox"/>	Frequent urine infections
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	Loss of control of urine
<input type="checkbox"/>	Decrease in flow
<input type="checkbox"/>	Urination more than 2x per night
<input type="checkbox"/>	Any venereal disease in the past? (Herpes, Chlamydia, Gonorrhea)

Psychological	
<input type="checkbox"/>	Feeling depressed
<input type="checkbox"/>	Nervous or anxious feeling
<input type="checkbox"/>	Excessive moodiness
<input type="checkbox"/>	Difficulty concentrating
<input type="checkbox"/>	Phobias/unexplained fears
<input type="checkbox"/>	Loss of pleasure in life

Substance/Chemical Use	
<input type="checkbox"/>	More than 6 drinks a week
<input type="checkbox"/>	Tobacco use
<input type="checkbox"/>	Caffeine use
<input type="checkbox"/>	Over-the-counter meds/vitamins

Cardiovascular	
<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Dizzy spells
<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Swollen ankles
<input type="checkbox"/>	Irregular pulse
<input type="checkbox"/>	Shortness of breath

Musculoskeletal	
<input type="checkbox"/>	Pain in joints
<input type="checkbox"/>	Pain in muscles
<input type="checkbox"/>	Recurrent back pains
<input type="checkbox"/>	Past injury to bones, spine, or joints
<input type="checkbox"/>	Gout attacks in the past
<input type="checkbox"/>	Concerned about osteoporosis

Endocrine	
<input type="checkbox"/>	Excessive thirst and urination
<input type="checkbox"/>	Feet and hands numbness/pain
<input type="checkbox"/>	Low blood sugar problems
<input type="checkbox"/>	Intolerance to heat or cold

Women only	
<input type="checkbox"/>	Irregular periods
<input type="checkbox"/>	Excessive flow/pain
<input type="checkbox"/>	Hot flashes/night sweats
<input type="checkbox"/>	Abnormal PAP smear

Pulmonary	
<input type="checkbox"/>	Pneumonia/pleurisy
<input type="checkbox"/>	Bronchitis/chronic cough
<input type="checkbox"/>	Asthma/wheezing

Anything else you want your doctor to be aware of?
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