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**

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Medical Review of Systems

Check next to any symptoms you have experienced since last visit/recently, or for which you have concerns about.

Name:_____

Date:_____

BP_____/_____ **p**_____ **Ht**_____ **Wt**_____

General	
	Recent unexpected weight loss
	Chronic fatigue
	Anemia
	Lack of regular exercise
	Overweight

Eyes	
	Failing vision
	Eye pain
	Double vision
	Blurred vision
	Frequent eye infections
	Glaucoma
	Cataracts

Ears, Nose, Mouth	
	Decreased hearing
	Ringing in ears
	Frequent ear infections
	Frequent nose bleeds
	Sinus trouble
	Frequent sore throat
	Prolonged hoarseness
	Tooth or jaw pain

Cardiovascular	
	Chest pain
	Dizzy spells
	Fainting spells
	High blood pressure
	Swollen ankles
	Irregular pulse
	Shortness of breath

Pulmonary	
	Pneumonia/pleurisy
	Bronchitis/chronic cough
	Asthma/wheezing

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

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

Musculoskeletal	
	Pain in joints
	Pain in muscles
	Recurrent back pains
	Past injury to bones, spine, or joints
	Gout attacks in the past
	Concerned about osteoporosis

Integumentary	
	Skin rashes
	Hives
	Skin moles – black or changing
	Breast mass
	Nipple discharge

Neurologic	
	Frequent headaches
	Tremor/hand shaking
	Muscle weakness
	Numbness/tingling
	Seizures/convulsions
	Difficulty sleeping
	Excessive daytime sleeping
	Memory loss

Psychological	
	Feeling depressed
	Nervous or anxious feeling
	Excessive moodiness
	Difficulty concentrating
	Phobias/unexplained fears
	Loss of pleasure in life

Endocrine	
	Excessive thirst and urination
	Feet and hands numbness/pain
	Low blood sugar problems
	Intolerance to heat or cold

Hematologic/Lymphatic	
	Excessive bruising
	Swollen glands in neck, armpit, or groin
	Unexplained fever, chills, night sweats

Allergic/Immunologic	
	Hay fever/allergies
	Acquiring many infections
	Desire HIV discussion

Substance/Chemical Use	
	More than 6 drinks a week
	Tobacco use
	Caffeine use
	Over-the-counter meds/vitamins

Women only	
	Irregular periods
	Excessive flow/pain
	Hot flashes/night sweats
	Abnormal PAP smear

Anything else you want your doctor to be aware of?