Patient Information

Identifying Information:

Name:_____ Date of Birth: _____

Age:_____ Gender: _____

Race: _____ Residence (City): _____

Medication Allergies:_____ Marital Status: M D S W

Occupation:_____ Currently Employed: Y N

PCP: _____ Pharmacy #: _____

Presenting Problems:

Brief Description of Current Problems:

_____

_____

_____

Psychiatric medications (use an additional page if necessary)

Current:

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Med: _____ Dose:_____ Frequency:_____ Duration:_____

Past: _____

Other Medications: (to include Vitamins, Herbals, etc.)

_____

Past Treatment:

Current/Past psychiatric diagnosis: _____

Previous Psychiatric Treatment:

In-Patient:	When: _____	When: _____
	Where: _____	Where: _____
	Why: _____	Why: _____
Out-Patient:	When: _____	When: _____
	Where: _____	Where: _____

Suicide Attempts: Y N If yes, _____

Habits:

Tobacco: _____ppd: _____ years: _____ Alcohol current: _____Past: _____

Caffeine _____cups coffee/day _____colas/day _____glasses of tea/day

Substance Abuse:

Please circle: None Past Present

Substance Used: _____ Age of Onset: _____

Amount/Frequency of Use: _____ Length of Use: _____

Consequences of Use: _____

Medical History:

Developmental Delays: Y N If yes: _____

Current/Chronic Illness: Y N If yes:

_____

_____

Surgeries: Y N If yes, _____

Head Injuries/Seizures: Y N If yes: _____

Difficulties during Delivery/Pregnancy: Y N If yes: _____

Current Nutritional Status: Weight: _____ Height: _____

Female Only: Age of onset of period:_____ Last period: _____ Birth control: _____

Age of Menopause: _____ Hormone replacement: _____

Family History:

Medical: Mother side: _____

Father side: _____

Sibling/Children: _____

Social History:

Current residence (City/State): _____

Name/Age of children: _____

#/Duration of Marriages: _____

Who lives in the home:

_____

_____

Childhood History:

Where were you born and raised: _____

Level of Education: _____

Number of siblings: Brothers: _____ Sisters: _____

Relationships:

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

_____

_____

Financial Issues: Y N If yes: _____

Legal Issues: Y N If yes: _____

_____ _____

Patient Signature Date

I have reviewed with patient and revised as needed the above patient information: Y N

_____ _____

Physician Signature Date

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**

UHS Rev 4/2020

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. **Have you felt you ought to cut down on your drinking or drug use?**
2. **Have people annoyed you by criticizing your drinking or drug use?**
3. **Have you felt bad or guilty about your drinking or drug use?**
4. **Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?**

Score: __ /4

2/4 or greater = positive CAGE, further evaluation is indicated

Source: **Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.**

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

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?