The Leggett Group: Psychiatric and Medical History Form

In preparation for a psychopharmacological consultation, please complete this form. Your answers will help your provider understand your history and the concerns you'd like to discuss during an evaluation. Please fill out as much of this questionnaire as possible. **Please note that your experiences with **past psychiatric treatment & medication are of particular importance** in allowing your provider to make the most informed recommendations.

Name: **Date of Birth:** **Today's Date:**

Emergency Contact: **Phone #:** **Relationship:**

Reason for Medication Consultation – Please explain why you are requesting a psychopharmacological consultation.

What are the psychiatric symptoms that you are currently experiencing?

Have you ever received a psychiatric diagnosis before? If so, what?

Name of Current/Past Medical Providers –

Name of Primary Care Provider (PCP)	**Name of Practice/Hospital**	**Phone #**	**Dates of Treatment**
Name of current Prescriber for psychiatric medication (psychiatrist, NP, PCP)	**Name of Practice/Hospital**	**Phone #**	**Dates of Treatment**
Name of current Psychotherapist	**Name of Practice/Hospital**	**Phone #**	**Dates of Treatment**

Please list ALL medications that you are currently taking, including:

- **psychotropic medication (**antidepressant, anti-anxiety, antipsychotic, mood stabilizer, or stimulant)
- **medications for medical problems**
- **any herbal remedies, vitamins, or nutraceuticals.**

Name of Medicine, Supplement, Vitamin	**Dose (mgs)**	**Frequency (how many times a day)**	**Start Date (MM/YY)**	**Response? Has it helped? Are there any concerns or side effects?**

Have you ever been treated with any of the following medications? **Circle all that apply and list any good or bad effects of the medications**

Antidepressants	**Sleep Aids**	**Antipsychotics**
Prozac (Fluoxetine)	Desyrel (Trazodone)	Abilify (Aripiprazole)
Paxil (Paroxetine)	Benadryl (Diphenhydramine)	Rexulti (Brexpiprazole)
Zoloft (Sertraline)	Melatonin	Seroquel (Quetiapine)
Celexa (Citalopram)	Ambien (Zolpidem)	Fanapt (Iloperidone)
Lexapro (Escitalopram)	Lunesta (Eszopiclone)	Saphris (Asenapine)
Luvox (Fluvoxamine)	Rozerem (Ramelteon)	Zyprexa (Olanzapine)
Effexor (Venlafaxine)	Neurontin (Gabapentin)	Invega (Paliperidone)
Pristiq (Desvenlafaxine)	Clonidine	Risperdal (Risperidone)
Cymbalta (Duloxetine)	Prazosin	Geodon (Ziprasidone)
Fetzima (Levomilnacipram)	Hydroxyzine	Latuda (Lurasidone)
Trintellix (Votioxetine)	**Benzodiazepines**	Haldol (Haloperidol)
Viibryd (Vilazodone)	Ativan (Lorazepam)	Thorazine (Chlorpromazine)
Wellbutrin (Bupropion)	Klonopin (Clonazepam)	Trilafon (Perphenazine)
Remeron (Mirtazapine)	Xanax (Alprazolam)	Stelazine (Trifluoperazine)
Serzone (Nefazodone)	Serax (Oxazepam)	Mellaril (Thioridazine)
Anafrinil (Clomipramine)	Valium (Diazepam)	**Stimulants**
Tofranil (Imipramine)	Restoril (Temazepam)	Ritalin/Concerta
Elavil (Amitriptyline)	Librium (Chlordiazepoxide)	Adderall
Norpramin (Desipramine)	**Mood Stabilizers**	Dexedrine
Pamelor (Nortriptyline)	Lithium	Provigil (Modafinil)
Sinequan (Doxepin)	Lamictal (Lamotrigine)	Strattera
Nardil (Phenelzine)	Depakote (Valproic Acid)	Vyvanse
Parnate (Tranylcypromine)	Tegretol (Carbamazepine)	Focalin
Emsam Patch (Selegiline)	Trileptal (Oxcarbazepine)	**Other?**

Family Psychiatric History – Has anyone in your family suffered from a mental health condition? _____Yes _____No

Condition	**Family Member**	**Condition**	**Family Member**
Depression		Schizophrenia/Psychosis	
ADHD		Bipolar Disorder	
Anxiety Disorder		Suicide	
Eating Disorder		Substance Abuse	

It is also helpful to know the experiences, **good or bad**, that your family members may have had with specific psychotropic medications. Family members often have similar reactions to medications.

Have you ever been hospitalized for a mental health condition? _____Yes ____No
– Please list the name of any hospital where you were admitted for psychiatric reasons, the dates that you were there, and the reason for admission.

Name of Hospital	**Date (Year)**	**Reason for admission**

Substance Use – Please note if you use any of the following:

Substance	**Current Use** How often? What amount?	**Past Use** How often? What amount?
Alcohol		
Nicotine (smoking)		
Marijuana		
Cocaine		
Stimulants/Amphetamines		
LSD/Hallucinogens		
Heroin/Opiates		

Have you ever had treatment for substance abuse or detox? ____ Yes ____ No If so, where and when: _____

Current Medical Concerns – Circle any symptoms that you are currently experiencing. Provide additional details on the side54t as needed.

General: Fever, chills, night sweats, weight change, loss of appetite, lack of energy	
Skin: Rashes, growing moles, non-healing lesions, itching, hair loss/increase	
Musculoskeletal: Bone pain, joint pain, joint swelling, muscle aches, history of fracture, neck pain, back pain	
Eyes: Last eye exam, change in vision, pain, double vision	
Ears: Pain, discharge, decreased hearing, ringing	
Nose: Bleeding, discharge, sinus pain	
Mouth & Throat: Sores, loose teeth, bleeding gums, post-nasal drip	
Immunologic: Enlarged nodes/tenderness, allergies, itching, frequent infections	
Hematologic: Bleeding, bruising, anemia, abnormal blood tests, leukemia, swelling	
Breasts: Lumps, pain, galactorrhea	
Respiratory: Cough, wheezing, shortness of breath, pain, snoring, daytime sleepiness	
Cardiovascular: Shortness of breath, orthopnea, swelling, chest discomfort, palpitations, syncope/fainting, irregular heartbeat	
Gastrointestinal: Trouble swallowing, heartburn, nausea, vomiting, pain, swelling, constipation, diarrhea, blood in stools, hemorrhoids, fecal incontinence, jaundice	
Genitourinary: Burning, pain, blood in urine, frequency, hesitancy, urgency, dribbling, frequent nighttime urination, incomplete emptying, incontinence, testicular mass, prostate problems, sexual dysfunction	

GYN: Currently Pregnant?, excessive bleeding, irregular bleeding, irregular cycle length, painful periods, hot flashes, peri/post- menopausal	*Last Menstrual Period =
Neurological: Paralysis, headaches, dizziness, weakness, change in sensation, paresthesia, loss of speech or vision, memory loss, vertigo, involuntary movements	

Past Medical History – Please **circle** to indicate if you have ever been diagnosed with any of the following conditions.

Diabetes	Coronary Artery Disease	Seizures	Autoimmune Disease
Kidney Disease	Heart Attack	Traumatic Brain Injury	Emphysema/COPD
Hepatitis/Liver Disease	High Blood Pressure	Migraines	Chronic Pain Condition
Tuberculosis	Arrhythmia	Polycystic Ovary Syndrome	Endocrine Disorder
Sexually Transmitted Disease	Stroke	Gynecological Disease	Sleep Apnea
Eye Problems Glaucoma	Congestive Heart Failure	Osteoporosis	Arthritis
Asthma	High Cholesterol	Gastrointestinal Disease	Anemia
Thyroid Problems	Cancer	Eating Disorder	*OTHER*

****Is there any other important information that you would like the prescribing clinician at The Leggett Group to know about you or your history?**