CONFIDENTIAL HEALTH HISTORY FORM

Amy R. Alson, MD, PLLC
205 East High Street, Charlottesville, VA 22902
P: 434-984-1100 F: 434-260-3853

Name_____ Date of birth_____

What is the primary reason for this appointment? _____

Please check off all current symptoms:

Symptom	
Depressed mood	
Unable to enjoy activities	
Loss of interest in enjoyable activities	
Excessive guilt	
Crying spells	
Problems with sleep	
Poor or increased appetite	
Decreased or increased libido	
Fatigue or excessive energy	
Impaired concentration	
Forgetfulness or memory problems	
Racing, rapid or intrusive thoughts	
Rapid or racing speech	
Increased risky or impulsive behavior	
Irritability	
Angry outbursts or violent behavior	
Ritualistic behavior	
Excessive worrying	
Avoidance	
Panic attacks	
Suspiciousness	
Altered perceptions (hearing seeing things others don't see or hear)	

Additional symptoms of concern:

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COMPREHENSIVE MEDICAL HISTORY

Drug allergies: _____

Environmental or food allergies: _____

Primary care physician: _____ Date of last physical exam: _____

Current or chronic general medical problems, if any: (anemia, asthma, heart problems, endocrine disorders, orthopedic problems, autoimmune disorders, cancer, et al):

Past medical problems, including non-psychiatric hospitalizations and surgeries:

Do you have any history of head injury or seizures? YES NO

How often do you exercise, if regularly? What kind of exercise do you do?

FOR WOMEN:

Date of last menstrual period: _____

Are your periods regular? YES NO

Have you ever been pregnant? YES NO

Are you pregnant or planning a pregnancy? YES NO

Birth control method, if using:

List your current prescription medications:

Medication	**Dose and frequency**	**Estimated start date**

Continue below if more space is needed, or provide a printed medication list

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List all current non-prescription medications, herbs, and supplements:

Medication	Dose and frequency	Estimated start date

Continue below if more space is needed, or provide a printed medication list

SUBSTANCE USE:

Have you or others ever considered your use of alcohol or other drugs to be a problem? YES NO

Have you ever intentionally misused prescription medication? YES NO

How many caffeinated beverages do you consume daily?

Do you now, or have you ever smoked or chewed tobacco? YES NO

PSYCHIATRIC HISTORY:

Past outpatient psychiatrist(s): _____
Past psychotherapist(s)_____

PAST Psychiatric Medications

Medication	Dose, if known	Benefit/side effects/why stopped

Continue below if you need more space, or provide a printed past medication list.

All past psychiatric hospitalizations or residential treatment:

Dates of admission	Reason for admission	Hospital or facility

Continue below if you need more space, or provide a separate list

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FAMILY MEDICAL HISTORY:

Condition	**Family member(s) affected**
Depression	
Bipolar disorder	
Anxiety disorder	
Obsessive Compulsive disorder	
Eating disorder	
Narcolepsy or other sleep disorder	
Schizophrenia	
Suicide attempt	
Other psychiatric disorder	
Diabetes, thyroid, or other endocrine system disorder	
Alcohol or drug dependence	
Liver disease	
Kidney disease	
Anemia	
Autoimmune disorders (Inflammatory bowel disease, Lupus, other)	
Heart disease or other circulatory system problems	
Stroke	
Epilepsy or seizure disorder	
Cancer (specify)	

Additional family medical conditions: