WOMEN'S BEHAVIORAL MEDICINE PATIENT QUESTIONNAIRE
PSYCHIATRIC/MEDICAL HISTORY **DATE: _____**

Name _____ DOB _____ Age _____

Please answer each of the following questions. Thank you.

Please describe the reason(s) why you are seeking treatment: _____
_____
_____
_____
_____

Please list any previous outpatient psychiatric/alcohol/substance abuse treatment: ☐ **None**

Date	Therapist/MD	Reason	Did it help?

Please list any previous psychiatric/alcohol/substance abuse hospitalizations: ☐ **None**

Date	Therapist/MD	Reason	Did it help?

Please list any psychiatric medications you are taking <u>NOW</u>. ☐ **None**

Drug	Dose	Frequency	Reason/Did it help?

Please list any psychiatric medications you have taken in the <u>PAST</u>. ☐ **None**

Drug	Dose	Frequency	Reason/Did it help?

Please complete the information requested below about your medical history.

Primary Physician's Name: _____ **Phone Number:** _____
Date of last physical exam: _____ **Any problems?** ☐ **No** ☐ **Yes, Describe:** _____
_____
_____
_____

Date of most recent routine blood tests:_____ **Date of most recent thyroid screen blood test:**_____

Obstetrician/Gynecologist's Name: _____ **Phone Number:** _____
Date of last pelvic exam: _____ **Any problems?** ☐ **No** ☐ **Yes, Describe:** _____
_____
_____
_____

Date of most recent mammogram: _____

Name: _____ **DOB:** _____

MEDICAL HISTORY

What is your height? _____ **What is your weight?** _____

Please check all that apply.

Disorder / Illness	Current	Past	Disorder / Illness	Current	Past
Arthritis / rheumatism	☐	☐	Joint problems	☐	☐
Asthma / breathing problems	☐	☐	Kidney problems	☐	☐
Cancer	☐	☐	Language / speech problems	☐	☐
Diabetes	☐	☐	Liver problems (e.g. hepatitis)	☐	☐
Digestive / stomach problems	☐	☐	Neurological problems	☐	☐
Dizziness / Vertigo	☐	☐	Pain, chronic or acute	☐	☐
Eating problems	☐	☐	Pregnancy problems	☐	☐
Gait (walking) problems	☐	☐	Seizure disorder	☐	☐
Genital or urinary problems	☐	☐	Sexually transmitted disease	☐	☐
Headaches	☐	☐	Skin problems	☐	☐
Head injury	☐	☐	Sleeping problems	☐	☐
Hearing problems	☐	☐	Stroke	☐	☐
Heart problems	☐	☐	Thyroid problems	☐	☐
Hormone problems	☐	☐	Tuberculosis	☐	☐
Hypertension	☐	☐	Vision Problems	☐	☐
Immuno-compromise problems (e.g. lupus, HIV)	☐	☐	Other:		

Do you drink alcohol? ☐ **No** ☐ **Yes – Amount** _____

Do you smoke cigarettes? ☐ **No** ☐ **Yes – Amount** _____

Have you ever been evaluated by a neurologist? ☐ **No** ☐ **Yes** **Date:** _____

Have you ever had an EEG (brain wave)? ☐ **No** ☐ **Yes** **Date:** _____

Have you ever had an MRI of the head? ☐ **No** ☐ **Yes** **Date:** _____

Have you ever had a CT Scan of the head? ☐ **No** ☐ **Yes** **Date:** _____

Please list current medical problems and specialists you currently receive treatment from. ☐ **None**

Problem	Physician Name/Specialty	Phone Number

Have you had previous hospitalizations for medical or surgical problems? ☐ **None**

Date	Problem	Hospital	Physician

Name: _____ **DOB:** _____

Please list any non-psychiatric medications you are currently taking. ☐ **None**

Drug	Dose	Frequency	Prescriber/Date Started

Pharmacy name, address and phone number: _____

Do you have any allergies or sensitivities to medication or environmental factors? ☐ **None**

Substance **Allergic Reaction or Sensitivity** **Mild/Moderate/Severe**

_____
_____
_____
_____

Are you pregnant now? ☐ **No** ☐ **Yes How many weeks?** _____
Have you ever been pregnant? ☐ **No** ☐ **Yes When?** _____
Have you ever had a miscarriage? ☐ **No** ☐ **Yes When?** _____
Have you ever terminated a pregnancy? ☐ **No** ☐ **Yes When?** _____
Do you have regular menstrual periods? ☐ **No** ☐ **Yes Last Menstrual Period:** _____

Do you have any pain or problems associated with your period? ☐ **No** ☐ **Yes**
Do you have any emotional symptoms before your period that resolve after it starts? ☐ **No** ☐ **Yes**
Do you have any signs or symptoms of menopause? ☐ **No** ☐ **Yes - Please circle:**

Hot flashes **night sweats** **vaginal dryness** **irregular periods** **broken sleep**

Educational History:
Level Achieved (e.g. high school, GED, graduate school) **Degree Earned/Major/Area of Interest**

_____
_____
_____
_____

Occupational History:
Job Titles **Dates**

_____
_____
_____
_____

Military service? ☐ **No** ☐ **Yes,** _____

Religion _____ **Current Spiritual Orientation** _____

Has anyone in your family ever had a psychiatric, alcohol or other substance abuse problem? ☐ **None**
Family Member (*e.g., Parent, sibling, aunt, grandmother, etc.)* **Problem**

_____
_____
_____

Reviewed by _____ **Date** _____

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