Kimberly Butler, PMHNP - Bend Psychiatry

PATIENT HISTORY FORM

PATIENT INFORMATION

Name	Date

Date of Birth	Age

Current Psychiatrist/Counselor	Current Primary Care Provider

MEDICATIONS

Please list all medications, including dosage and frequency

ALLERGIES

Please list all allergies including medication, food, and environmental

FAMILY HISTORY

Has a parent, grandparent, sibling, or child ever had the following?

	No	Yes		No	Yes
Cancer	☐	☐	Suicide	☐	☐
Heart Disease	☐	☐	Mental Illness	☐	☐
Diabetes	☐	☐	Drug or Alcohol Abuse	☐	☐
Stroke	☐	☐			

	Mother	Father	Sisters	Brothers	Daughters	Sons
Age/Health						
(Good or Poor)						
Age at Death						
Cause of Death						

YOUR PAST MEDICAL HISTORY

Do **you** have any health issues related to the following?

	No	Yes		No	Yes
Cancer	☐	☐	Concussion	☐	☐
Heart	☐	☐	Migraines	☐	☐
Diabetes	☐	☐	Vision	☐	☐
Stroke	☐	☐	Hearing	☐	☐
Thyroid	☐	☐	Stomach or Intestine	☐	☐
Seizures	☐	☐	Liver	☐	☐
Meningitis	☐	☐	Kidneys	☐	☐
Encephalitis	☐	☐	Musculoskeletal Pain	☐	☐
Head Injury	☐	☐	Sexually Transmitted Disease	☐	☐

Patient Name

Have you ever been hospitalized? If so, for what reason?

Have you ever had surgery? If so, what type and date (year)?

Past Psychiatrists (MD)/Psychiatric Nurse Practitioners (PMHNP)/Counselors (PhD, PsyD, LPC, LCSW, MSW)

Past PSYCHIATRIC MEDICATIONS

Medication Name	Maximum Dose	Side Effects?	Benefit?

SOCIAL HISTORY

Circle One:

Single	Married	Divorced	Separated	Widowed	Significant Other

With whom do you live?

Are you currently employed? If so, where and for how long?

If employed, how much time have you lost from work because of your health in the last:

6 months:	12 months:	5 years:

Are you exposed to any harmful fumes, dusts, solvents, or other chemicals? If so, what?

Have you traveled outside of the U.S. in the last 12 months? If so, where and how long?

Please indicate whether you consume each of the following & amount?

	No	Yes	Amount
Caffeine	☐	☐	Cups/Ounces/Day:
Energy Drinks	☐	☐	Ounces/Day:
Tobacco	☐	☐	Packs/Day:
Alcohol	☐	☐	Drinks/Day:
Marijuana/Cannabis	☐	☐	Amount:
Recreational Drug Use	☐	☐	Type & Amount:

What are the top 3 things you would like help with?

1
2
3