Anne Arundel Medical Group
Mental Health Specialists

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ADULT INITIAL PSYCHIATRIC VISIT QUESTIONNAIRE

Name: _____ DOB: _____

Please check and answer or explain where indicated

1. **What is the purpose of your visit? (Check all that apply)**
   ☐Evaluation ☐Second opinion ☐Consultation
   ☐Medication management ☐Therapy ☐ Other: _____

2. **What is your preferred pharmacy information?**
   Name:_____
   Contact Number: (____) ____ - _____
   Address: _____

3. **Please list the name and contact number for your primary care provider:**
   Name: _____ Phone Number: (_____) _____ - _____

What are your main reasons for coming to treatment?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

OFFICE USE ONLY

❑ NEW REFERRAL ❑ AAMC REFERRAL ❑ PATHWAYS REFERRAL ❑ Commercial ❑ Medicare/Medicaid ❑ Self-Pay

PSYCHIATRIC HISTORY

4. **Have you received any *previous* outpatient mental health treatment?** ☐Yes ☐No

   If yes, please list all outpatient treatment providers and specialty (therapy/medication):

Name	Therapy or Medication	Diagnosis Given	Phone
1.			
2.			
3.			
4.			
5.			

5. **Have you received any *previous* inpatient mental health treatment?** ☐Yes ☐No

   If yes, please complete the following information:

Name of Hospital	Date of inpatient admission	Reason	Diagnosis Given
1.			
2.			
3.			
4.			
5.			

6. **Please list all *current* psychiatric medications the you are prescribed**

Medication	Dosage	Frequency	Prescribed by:
1.			
2.			
3.			
4.			
5.			

7. **Please list all psychiatric medications that you are *no longer* prescribed and the reason**

Medication	Reason the medication was discontinued
1.	
2.	
3.	
4.	
5.	

MEDICAL HISTORY

8. Check all that apply to the patient

☐Anemia	☐Cataracts	☐Emphysema	☐ HIV/AIDS	☐ Osteoporosis
☐Arthritis	☐CHF	☐GERD	☐Hyperlipidemia	☐ Seizures
☐Asthma	☐Clotting disorder	☐Glaucoma	☐Hypertension	☐ Sickle Cell
☐Blood transfusion	☐COPD	☐Heart Attack	☐ Kidney disease	☐ Stroke
☐Cancer	☐Diabetes	☐Heart Murmur	☐Meningitis	☐Thyroid Disease

☐Other: _____

_____

_____

SURGICAL HISTORY

9. Check all that apply to the patient

☐Appendectomy	☐Colon Surgery	☐Hernia Repair	☐ Spine Surgery
☐Brain surgery	☐Cosmetic Surgery	☐Hysterectomy	☐Tubal Ligation
☐Breast surgery	☐C-section	☐Joint Replacement	☐Valve Replacement
☐CABG	☐Eye surgery	☐Prostate Surgery	☐ Vasectomy
☐Cholecystectomy	☐Fracture surgery	☐Small Intestine Surgery	

☐Other: _____

_____

_____

ALLERGIES

10. Please list any allergies and the reaction

Medication or Substance	Reaction
1.	
2.	
3.	
4.	
5.	

MEDICATIONS

11. Please list all current medications, dosage, and how often taken:

Name of Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		

12. **Please list any other medication being taken** (herbal, over the counter, etc.)

Medication	Reason
1.	
2.	
3.	
4.	
5.	

FAMILY HISTORY

13. **Is there a biological family history (blood relatives of the patient: mom, dad, siblings, cousins, aunts, uncles, grandparents) of mental health issues or substance abuse issues?**
    ☐Yes ☐No
    If yes, please explain:

    _____

    _____

14. **Is there a biological family history (blood relatives of the patient) of medical problems (heart problems, cancer, sudden death of unknown cause, lupus, dementia, Alzheimer's Parkinson's, diabetes, etc)?**
    ☐Yes ☐No
    If yes, please explain:

    _____

    _____

TOBACCO USE HISTORY

15. **Do you smoke?** ☐Yes ☐No
    If yes:
    When did you start smoking?_____

    How much do you smoke on a daily basis?_____

16. **Did you previously smoke cigarettes?** ☐Yes ☐No
    If yes:
    How many years did you smoke for?_____

    When did you quit smoking? _____

Signatures:
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Signature of Patient **Date**