SURYA PSYCHIATRIC CLINIC

Strive TMS Centers

SHIFTING THE PARADIGM

MEDICAL HISTORY QUESTIONNAIRE

This is your medical history form, to be completed prior to your visit. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin treatment. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a comprehensive treatment program that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: ____

Date: ____

What concern(s) bring(s) you to the Surya Psychiatric Clinic and Strive TMS Centers?

____

____

____

What are your treatment goals?

____

____

____

Are you CURRENTLY experiencing any of the following symptoms?

Depression	Worrying excessively	Hearing voices
Loss of Interest in activities	Having tense muscle	Seeing things
Feeling hopeless or worthless	So anxious you feel you cannot rest or relax	Smelling things
Poor energy or fatigue	Panic attacks	Feeling abnormal sensations in skin
Change in appetite (⇑ or ⇓)	Traumatic events that come back in nightmares, flashbacks	Feeling people were trying to watch or harm you
Poor self-esteem	Feeling awkward in public	Concerns about alcohol or drug use
Poor focus or concentration	Thoughts that replay	Concerns about eating too much
Thoughts of not being alive	Repetitive or compulsive behaviors or rituals	Eating too little
Problems going to sleep	Phobias or fears	Memory Problems
Periods of euphoria or unusually good mood	Grunts, tics, or jerks	Getting lost easily
Going days w/o needing to sleep	Inattentiveness at work or School	Forgetting how to do tasks
Racing thoughts	Hyperactivity or fidgety	Problems finding words
Talking too fast	Acting impulsively(spending, Speeding, hypersexuality, etc.)	Problems with caring for self (cooking, dressing, etc.)

When was the first time you experienced any condition relating to your emotions? Age________ Year_________

Have you ever been diagnosed with any of the following?

Depression	Panic Disorder	Alcoholism
Bipolar Disorder	Social Anxiety Disorder	Drug addiction
ADHD	Generalized Anxiety Disorder	Eating Disorder
OCD	Borderline Personality Disorder	Other (please Specify below)
PTSD	Schizophrenia or Schizoaffective d/o	

Have you ever been seen by a psychiatrist, psychology, therapist/counselor, or mental health professional? Please list and describe.

Name of Provider	Dates Treated	Condition Treated	Treatment Modes (Medication, Therapy, Nutrition, ECT and/or etc.)

Have you ever been hospitalized for psychiatric care? Please list and describe?

Date Treated	Condition Treated	Treatment Modes (Medication, Therapy, Nutrition, ECT and/or etc.)

Safety

Do you currently have thoughts of hurting yourself or others? __________Yes ___________No

If yes, SELF_______________ OTHERS________________

How often do you have these thoughts? ____

Time of last thoughts? ____

Has anything happened recently to make you feel this way? ____

On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill self or others? ______________________________________

Would anything make it better? ____

Have you thought about how you would kill (self or others)? ____

Have you planned a time for this? ____

Is there anything that would stop you from killing yourself or others? ____

Do you feel hopeless and/or worthless? ____

Have you tried to hurt yourself/others in the past? If so, please explain:

____

Do you own or have access to any guns or weapons? ____

Have you ever been treated with any of the following medications? (If you can't remember all the details, just write as much as you recall).

Medications Name AND Class	Dates, Dosages, Positive/Negative response, Side-effects, Purpose of Usage	Medications Name AND Class	Dates, Dosages, Positive/Negative response, Side-effects, Purpose of Usage
Antidepressants			
Prozac (Fluoxetine)		Trintellix (Vortioxetine)	
Zoloft (Sertraline)		Wellbutrin (Burpoprion)	
Paxil (Paroxetine)		Remeron (Mirtazapine)	
Luvox (Fluvoxamine)		Serzone (Nefazodone)	
Celexa (Citalopram)		Anafranil (Clomipramine)	
Lexapro (Escitalopram)		Pamelor (Nortriptyline)	
Effexor (Venlafaxine)		Elavil (Amitriptyline)	
Cymbalta (Duloxetine)		Tofranil (Imipramine)	
Pristiq (Desvenlafaxine)		Nardil (Phenelzine)	
Fetzima (Levomilnacipran)		Parnate (Tranylcypromine)	
Viibryd (Vilazodone)		Emsam (Selegiline) Patch	

Mood Stabilizers			
Lithium		Trileptal (Oxcarbazepine)	
Depakote (Valporate)		Topamax (Topiramate)	
Tegretol (Carbamazepine)		Lamictal (Lamotrigine)	

Antipsychotics/Mood Stabilizers

Risperdal (Risperidone)		Fanapt (Iloperidone)	
Zyprexa (Olanzapine)		Latuda (Lurasidone)	
Seroquel (Quetiapine)		Rexulti (brexpripazole)	
Geodon (Ziprasidone)		Haldol (Haloperidol)	
Abilify (Aripripazole)		Prolixin (Fluphenazine)	
Clozaril (Clozapine)		Orap (Pimozide)	
Invega (Paliperidone)		Vraylar (Cariprazine)	
Saphris (Asenapine)		Thorazine (Chlorpromazine)	

Anti-Anxiety Medications			
Xanax (Alprazolam)		Tranxene (Clarazepate)	
Ativan (Lorazepam)		Librium (Chlordiazepoxide)	
Klonopin (Clonazepam)		Buspar (Buspirone)	
Valium (Diazepam)			

ADHD Medications			
Adderall (Amphetamine Salts)		Vyvance (Lisdexamfetamine)	
Ritalin (Methylphenidate)		Dexedrine(Dextroamphetamine)	
Strattera (Atomoxetine)			

Sedative/Hypnotics			
Ambien (Zolpidem)		Restoril (Temazepam)	
Sonata (Zaleplon)		Lunesta (	
Rozerem (Ramelteon)		Trazodone	

Other			
Revia/Vivitrol (Naltrexone)		Neurontin (Gabapentin)	
Campral (Acamprosate)		Suboxone/Subutex	
Methadone		Symmetrel (Amantadine)	
Any Other Psychiatric Meds?			

Past Medical Care

Primary Care Doctor: ____

List of Current Medical Conditions:

____

____

List of Past Surgeries:

____

____

Please list ALL medications you are currently taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	Condition Treated	Prescribing Provider

History of Head Injury ____Yes ____No If yes, please explain:____
Describe any allergies you have (e.g. to medications, foods)

____

* WOMEN ONLY *

Last menstrual period: ____ Usually regular? _____ Yes_____ No
Do you use any birth control? _____ Yes_____ No If yes, please list ____
Have you been pregnant before? _____ Yes_____ No If yes, how many times? ____
Have you experienced any miscarriages? _____ Yes_____ No
Have you ever elected for an abortion? _____ Yes_____ No
Any depression and/or unreal thoughts around pregnancies? _____ Yes_____ No
If yes, please explain__________________________
Are you post-menopausal/had a hysterectomy/ had tubal ligation? _____ Yes_____ No

Substance Use History

How often have you used the following substances?

	Approximately how often (# of times per week, month, or year)?	How much do you use in a sitting if/when you do use?	Date of Last Usage
Tobacco			
Alcohol			
Marijuana or K2/ "Spice"			
Cocaine			
Methamphetamines/Speed			
Opiates (e.g. Heroin, Morphine, Percocet, Oxycodone, Tylenol #3, Dilaudid /Hydromorphone etc.)			
Tranquilizers/sedative (e.g. Xanax, Ativan, Klonopin, Valium etc.)			
PCP or LSD			
Mushrooms			
Others______________			

Have you had any history of substance abuse treatment? _____ Yes_____ No If yes, explain:__________________________________
Did you ever face legal issues due to substance use? _____ Yes_____ No If yes, explain:_______________________________________
Have you ever found yourself feeling you need to cut down the usage? _____ Yes_____ No
Have people annoyed you by criticizing your drinking/drug use? _____ Yes_____ No
Have you ever felt guilty or bad about the usage? _____ Yes_____ No
Have you ever had a brink or used first thing in the morning to steady your nerves or to subside a hangover? _____ Yes_____ No
Do you think you may have a problem with substance abuse? _____ Yes_____ No
Have you ever abused prescription medication or take any medication that is not prescribed for you (such as opiates)? __ Yes__ No

Family History:

Relative	Alive/Deceased	Age	Quality of relationship with them:	If deceased, please specify COD
Father				
Mother				

Sibling #1				
Sibling #2				
Sibling #3				
Sibling #4				

Were you adopted? _____ Yes_____ No
Did your parents divorce? _____ Yes_____ No
If so, how old where you when they divorced? ____If your parents' divorce, who did you live with? ____________________

Please list ALL blood relatives who have been diagnosed with the following conditions.

Conditions	Relatives
Alcoholism	
Anxiety Disorders	
Bipolar Disorder	
ADHD	
OCD	
PTSD	
Parkinson's Disease	
Cancer	
Depression	
Dementia/Alzheimer's Disease	
Diabetes	
Drug Use	
Heart disease/high blood pressure/arrhythmias	
Seizures	
Schizophrenia	
Stokes	
Suicide/Self harm behaviors	
Thyroid Disease	
Any other psychiatric/ Medical conditions (please specify)	

Has any family member been treated with a psychiatric medications? _____ Yes_____ No
If yes, who was treated and what medications and how effective was treatment?

___

Who lives with you? ____
Highest level of education? ____
What is your current job/occupation? ____________________________________
What jobs have you had in the past? _____________________________________
What is your relationship status? ____
If married or in relationship, how long? ____________________________________
Have you been married in the past? _____ Yes_____ No ________ # of times
Do you have children? _____ Yes_____ No
If so, how many, what are their ages? ________________
What do you do in your free time to relax? ___________________________________

Do you have religious beliefs? _____ Yes_____ No

If so, describe ____

Have you experienced any legal issues (e.g. arrests, charges, time in jail/prison, probation/parole)? _____ Yes_____ No

If so, please describe ____

Have you ever been the victim of a violent crime? _____ Yes_____ No

Have you ever been a victim of physical, emotional, verbal, sexual abuse or rape? If so, please explain (as much as you can)

____

Have you ever served in military? _____ Yes_____ No

If so, what branch and when? ______________

Any combat experience? _____ Yes_____ No

Honorable discharge _____ Yes_____ No

Have you been engaged in self-injurious behaviors (such as superficial cutting, burning, hitting? _____ Yes_____ No

If so, please describe____

Do you have a history of anger (verbal or physical bashing, punching, throwing objects, and etc.)?

Is there anything else that you would like your provider to know? We wish to hear everything from our clients (positive or negative). Please don't hesitate to tell us your thoughts.

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QUICK CHECKLIST: Review of CURRENT Symptoms

Yes	SYMPTOMS	Yes	SYMPTOMS	Yes	SYMPTOMS	Yes	SYMPTOMS
	Weight Loss		Joint Pain/Swelling		Sinus Trouble		Lesions
	Fatigue		Stiffness		Nasal Stuffiness		Itching/burning
	Fever		Muscle Pain		Frequent Sore Throat		Loss of Strength
	Glasses/Contacts		Back Pain		Hives/Eczema		Numbness/Tingling
	Eye Pain		Heartburn/reflux		Hay Fever		Headaches
	Double Vision		Nausea/Vomiting		Murmur		Tremors
	Cataracts		Constipation		Chest Pain		Memory Loss
	Difficulty Hearing		Jaundice		Palpitations		Cough Easily
	Ringing in Ears		Black or bloody Bowel Movement		Dizziness		Coughing Blood
	Burning/frequency of urination		Change in Bowel Movements		Fainting Spells		Wheezing
	Nighttime Urination		Abdominal Pain		Shortness of breath		Chills
	Blood in Urine		Diarrhea		Difficulty lying Flat		Loss of Hair
	Erectile Dysfunction		Easy Bruising		Swelling Ankles		Heat/Cold Intolerance
	Abnormal Discharge		Gums Bleed Easily		Vertigo		Rash/Sores
	Bladder Leakage		Enlarged Glands				

I, attest, I have filled this form out to the best of my knowledge.

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Signature of Patient