Michigan State University Department of Psychiatry

Personal History

Patient Name: ______________________

MRN: ______________________

Name: ____________________ Birth Date: ______________ Age: ______

Ethnicity: ______________ Gender: ______________

Who referred you to our practice? ______________________________

Primary care physician: ______________________________

Therapist: ______________________________

HISTORY OF CURRENT PROBLEM:

Please explain why you are coming in for treatment:

____

____

____

____

When did the problem start? ______________________________

Explain any associated factors that contributed or precipitated the above problem:

____

____

PAST PSYCHIATRIC TREATMENT:

Past Psychiatrist:	Dates:
Past Therapist:	**Dates:**
Past Psychiatric Hospitalizations:	**Dates:**

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CIRCLE MEDICATIONS TRIED:

SSRIs:
Celexa (citalopram)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Paxil (paroxetine)
Prozac (fluoxetine)
Zoloft (sertraline)

SNRIs:
Cymbalta (duloxetine)
Effexor (venlafaxine)
Pristiq (desvenlafaxine)

Other Antidepressants:
Brintellix (vortioxetine)
Remeron (mirtazapine)
Serzone (nefazasone)
Viibryd (vilazodone)
Wellbutrin (bupropion)

TCAs:
Anafranil (clomipramine)
Elavil (amitriptyline)
Norpramin (desipramine)
Pamelor (nortriptyline)
Silenor (doxepin)
Tofranil (imipramine)

Thyroid Medication

MAOIs:
Emsam (selegiline)
Marplan (isocarboxazid)
Nardil (phenelzine)
Parnate (tranylcypromine)

Anticonvulsants / Mood stabilizers:
Depakote (valproic acid)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Lithobid / Eskalith (lithium)
Lyrica (pregabalin)
Neurontin (gabapentin)
Tegretol (carbamazepine)
Trileptal (oxcarbazepine)
Topamax (topiramate)

Anxiolytics:
Atarax / Vistaril (hydroxyzine)
BuSpar (buspirone)

Benzodiazepines:
Xanax (alprazolam)
Ativan (lorazepam)
Klonopin (clonazepam)
Valium (diazepam)

Antipsychotics:
Abilify (aripiprazole)
Clozaril (clozapine)
Fanapt (iloperidone)
Geodon (ziprasidone)
Haldol (haloperidol)
Invega (paliperidone)
Pimozide (Orap)
Prolixin (fluphenazine)
Risperdal (risperidone)
Saphris (asenapine)
Seroquel (quetiapine)
Thorazine (chlorpromazine)
Zyprexa (olanzapine)
Cogentin (benztropine)

Stimulants:
Adderall (amphetamine)
Concerta / Daytrana / Ritalin / Methylin (methylphenidate)
Dexedrine (dextroamphetamine)
Focalin (dexmethylphenidate)
Vyvanse (lisdexamfetamine)

Non stimulant:
Intuniv / Tenex (guanfacine)
Kapvay (clonidine)
Strattera (atomoxetine)

Sleep:
Melatonin
Rozerem (ramelteon)
Benadryl (diphenhydramine)
NyQuil / Unisom (doxylamine)
Desyrel (Trazodone)
Ambien (zolpidem)
Lunesta (eszopiclone)
Restoril (temazepam)

Substance treatment:
Zyban (bupropion)
Chantix (varenicline)
Antabuse (disulfiram)
Campral (acomprosate)
Subutex (buprenorphine)
Suboxone (buprenorphine/naloxone)
Methadone
Vivitrol / ReVia (Naltrexone)

Other(s):____

____

FOR EACH MEDICATION CIRCLED, PROVIDE ADDITIONAL INFORMATION BELOW:

Medication:	Date Started	Date Ended	Side Effects	Reason for Discontinuation	Helpful?

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DEVELOPMENTAL HISTORY:

Your birth: ☐ Premature ☐ Full Term ☐Post Term

How you were delivered: ☐ Vaginal ☐ C-section ☐ Other: ________________

Did your mother use substances during pregnancy: ☐ No ☐ Yes If Yes, describe:

____

Did you reach milestones (talking, walking, feeding self… etc.) on time?

☐ Yes ☐ No If No, describe: ____

Have you ever received special education accommodations?

☐ No ☐ Yes If Yes, describe: ____

Highest level of education completed?

____

History of being bullied as a child: ☐ No ☐ Yes If Yes, describe:

____

History of childhood abuse (sexual/emotional/physical): ☐ No ☐ Yes If Yes, describe:

____

____

Check the appropriate box below for any family member who had / has a psychiatric diagnosis:

		Paternal (Father) Family:					Maternal (Mother) Family:				
	Sibling	Father	Aunt	Uncle	Grandparent	Cousin	Mother	Aunt	Uncle	Grandparent	Cousin
Depression											
Anxiety											
Obsessions or Compulsions											
Mania or Bipolar Disorder											
Psychosis or Schizophrenia											
Attention or Concentration Problems											
Hyperactivity Problems											
Learning Problems											
Mental Retardation											
Alcohol Problems											
Drug Use Problems											
Legal Problems											
Abuse or Neglect											
History of Suicide Attempts											
History of Self Harming											
Psychiatric Hospitalizations											
Use of Psychiatric Medications											

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MEDICAL HISTORY:

Medical problems: (Check all that apply)

□ High Blood Pressure	□ Emphysema/COPD	□ Heart Disease	□ Diabetes
□ Heart Failure	□ GERD/Reflux	□ Sleep Apnea	□ HIV/AIDS
□ Gastric Bypass	□ Concussion	□ Liver Disease	□ Stroke
□ Thyroid disease	□ Kidney Disease	□ Epilepsy/Seizures	□ Asthma
□ Multiple Sclerosis	□ Fibromyalgia/CFS	□ UC/Crohn's Disease	□ Cancer: __________
□ Arthritis	□ High Cholesterol	□ Other: ___________	□ Other: ___________

Surgeries:

____

____

Medication allergies: ____

____

Current medications: ____

____

Other providers you see:

____

____

SOCIAL HISTORY:

Marital Status – (please circle):

Single Dating Married/Partner Married for second or more times

Divorced – not remarried Separated Widowed

Who lives in your household:____

List ages of your children: ____

Current occupation: ____

Past occupation (s): ____

List and explain any legal problems: ______________________________________

____

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SUBSTANCE USE:

Drug Type or Name	Age of First Use	Amount Used at Height of Use	Current Amount Used and Frequency	Last Use	Never Used
Marijuana					
Alcohol					
Nicotine					
Cocaine					
Heroin					
LSD					
PCP					
Stimulants					
Pain Medications (List below): ________________ ________________					
Other: ________________					

REVIEW OF SYSTEMS:

Please check box marked **YES if** you have experienced any of the following:

Yes **CONSTITUTIONAL**
- ☐ Fevers/ chills
- ☐ Weight loss/ gain
- ☐ Changes to energy level
- ☐ Sleep problems

Yes **HEENT**
- ☐ Glasses
- ☐ Double vision
- ☐ Hearing problems
- ☐ Ear infections/ ear pain
- ☐ Seasonal / environmental allergies
- ☐ Strep throat
- ☐ Sinus problems

Yes **NEUROLOGY**
- ☐ Vision changes or problems
- ☐ Head injury/ concussion
- ☐ Trouble walking / clumsiness
- ☐ Seizures
- ☐ Headaches
- ☐ Numbness/ tingling

Yes **CARDIOVASCULAR**
- ☐ Chest pain
- ☐ Fainting
- ☐ Feeling heart beating or racing
- ☐ Problems with blood pressure
- ☐ Heart murmur

Yes **PULMONARY**
- ☐ Wheezing or asthma
- ☐ Trouble breathing

Yes **ENDOCRINE**
- ☐ Intolerance to heat or cold
- ☐ Unusual weight changes
- ☐ Problems with blood sugar
- ☐ History of diabetes
- ☐ Change in hair or nails

Yes **HEMATOLOGY**
- ☐ Bleeding problems
- ☐ Abnormal bruising

Yes **GASTROENTEROLOY**
- ☐ Frequent stomach aches
- ☐ Nausea and/or vomiting
- ☐ Diarrhea
- ☐ Constipation

Yes **GENITOURINARY**
- ☐ Problems urinating
- ☐ Bladder or kidney infections
- ☐ Incontinence

Yes **MUSCULOSKELETAL**
- ☐ Joint pain / swelling
- ☐ Muscle weakness

Yes **SKIN**
- ☐ Rashes
- ☐ Picking
- ☐ Large or unusual birthmark

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