

Date of Visit:

Health History

Name: _____ Age: _____
Marital Status: _____

Current symptoms: _____ Age of Onset: _____ Frequency: _____

Have you ever received mental health treatment? If so, list dates & provider name: _____

What medications have you tried in the past for mood or nervousness?

Have you ever had a suicide attempt-how many times, when? _____
Have you ever been in a psychiatric hospital or rehab, when? _____

Medical history _____ Surgeries _____
What _____

Current medications, including prescription and over-the-counter: _____
Vitamins/minerals/supplements: _____
Allergic reactions to medications: _____

Family members who have ever been on medications for mood or anxiety: _____
Blood relatives ever in a psychiatric hospital or had a suicide attempt: _____

Tobacco
Never used ___ Packs per day ____
Alcohol
Never used ___ Estimated drinks per day ____
Other drugs
Never used ___ Frequency ____
Caffeine
None ___ How much ____

Birthplace _____ Number of siblings _____ Grade completed _____
Training, military, or education beyond high school: _____
Occupation: _____
What hobbies or interests do you have? _____
How often do you exercise? _____
With whom do you live? _____ Sons ages: _____ Daughters ages: _____

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