Psychiatric Associates, P.A.
Michas, Valentine & Gill,
CONFIDENTIAL MEDICAL QUESTIONNAIRE

Patient Name _____ **Date of Birth** _____

Address _____**City**_____ **St**_____**Zip**_____

Social Security # : _____ **Home Phone** _____**Cell Phone**_____

Email _____**Preferred Communication** ( ) Home ( ) Work ( ) Cell ( ) Email

Religious Affiliation _____ **Race**_____ **Ethnicity**_____

Occupation _____ **Employer/School** _____

Highest level of education: _____

If the patient is a minor:

Mother's Name _____ Work Phone _____ Cell Phone _____

Father's Name _____ Work Phone _____ Cell Phone _____

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Other ( )

Spouse's Name _____ Age _____ Occupation _____

Living Arrangements: _____

Number of Years Married _____ **Number of Child(ren)** _____ **(List Below)**

Name _____ Age _____ Gender ____ Name _____ Age _____ Gender ____

Name _____ Age _____ Gender ____ Name _____ Age _____ Gender ____

Emergency Contact:

Name _____ Relationship: _____

Address: _____Telephone Number _____

Next of Kin:

Name _____ Relationship: _____

Address: _____Telephone Number _____

***I authorize Psychiatric Associates, P.A. to contact the person above in the event of an emergency. Initials _____**

Primary Medical Doctor _____ **Phone**_____

Last Exam Date _____ **Current Height** _____ **Current Weight** _____

Significant medical problems (including past surgeries) _____

_____

Current Medications:

_____MG____How your taking it_____ Prescribing Dr _____

_____MG____How your taking it_____ Prescribing Dr _____

_____MG____How your taking it_____ Prescribing Dr _____

_____MG____How your taking it_____ Prescribing Dr _____

Pharmacy Name _____ **Pharmacy Phone** _____

Family Medical History

List your siblings (including yourself) in birth order:

Name _____ Age _____ Gender ____ Name _____ Age _____ Gender ____

Name _____ Age _____ Gender ____ Name _____ Age _____ Gender ____

Please list health status/cause of death of the following:

Mother: Good ( ) Fair ( ) Poor ( ) N/A ( ) _____

Father: Good ( ) Fair ( ) Poor ( ) N/A ( ) _____

Siblings: Good ( ) Fair ( ) Poor ( ) N/A ( ) _____

Children: Good ( ) Fair ( ) Poor ( ) N/A ( ) _____

Are there any specific disorders/diseases in your family relating to psychiatric illness? (If so, please list the condition and the family member affected) _____

_____

Do you use tobacco? Yes No **Frequency:** 1-5 6-10 1/2 pack 1pk 1 1/2 pk 2pk 2 1/2pk

How long ago did you start? _____ **How often do you smoke?** _____ **Last time smoked?** _____

Do you use alcohol? Yes No If so, what purpose? _____ (i.e. Social, everyday)

What type? _____ On average, how many drinks? _____

How long? _____ How often? _____ Last time you drank? _____

Do you use illicit (street) drugs? Yes No

What type? _____How long? _____How often? _____ Last used? _____

Family History: Alcoholism ( ) Substance Abuse ( ) Mental Illness ( ) Physical Illness ( ) Sexual Abuse ( )

Explain _____

Previous suicide attempts? Yes ( ) No ( ) **How many?** _____ **Suicidal thoughts?** Yes ( ) No ( )

Previous history of violence? Yes ( ) No ( ) **History of arrests?** Yes ( ) No ( ) (please give details for any yes answer below)_____

_____

Previous psychiatric care and/or counseling? Yes ( ) No ( ) If yes, please complete the following information:

Date	Age at Time of Treatment	Type of Treatment* (select type from below)	Primary Reason	Length of Care
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

***Outpatient, Inpatient, Medication Management, Psychotherapy, Individual, Group, Family, Other**

_____ _____ _____

Patient Signature Witness Signature Date