USF Mood & Anxiety Disorders Program

2 Tampa General Circle, 2nd floor, Tampa, Florida 33606 ▪ 813-974-8900 ▪ 813-974-3223 fax

New Patient Information

Demographic Information **Date:** _ _ / _ _ / _ _ _ _

Please fill out this packet to the best of your ability.

Name: ____
Last First Middle

Date of Birth: _ _ / _ _ / _ _ _ _ Age: _____ years

Sex: Male ___ Female ___

Primary Phone: _ _ _ / _ _ _ / _ _ _ _ Secondary Phone: _ _ _ / _ _ _ / _ _ _ _

E- mail: ____

Social Security No ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Mailing Address: ____

____

Contact Person: ____

Relationship: ____

Primary Phone: _ _ _ / _ _ _ / _ _ _ _ Secondary Phone: _ _ _ / _ _ _ / _ _ _ _

□ Contact in emergency only

Ethnicity: Hispanic ___ Non-Hispanic ___

Race: Black/African American ___ Asian ___ Native American/ Alaskan Native ___

Native Hawaiian/Pacific Islander ___ White ___ Other (Specify) ______________________

Referring Physician Information

Were you referred to USF Department of Psychiatry by a physician? □Yes □ No

If so, Please complete the following:

Name of Referring Physician ______________________ Specialty ______________________

Address ____

Phone ______________________ Fax ______________________

Primary Care Physician Information

Do you have a Primary Care Physician (one who is responsible for your overall healthcare and/or the one who has to authorize your treatment at USF Department of Psychiatry because you belong to an HMO/PPO insurance program)? □Yes □ No

Name of Primary Care Physician ______________________ Specialty ______________________

Address ____

Phone ______________________ Fax ______________________

USF Mood & Anxiety Disorders Program

Clinical Information

Reason for evaluation: ____

Allergies to Medication/Foods and type of reaction: ____

____

Current Medications & Herbal Treatments:

Name	Dose	Date Started	Reason Taking

For Women Only:

Date of Last Menstrual Cycle: _ _ / _ _ / _ _ _ _

Chance of Being Pregnant: None __ Possible __ Definite __

Form of Birth Control: ____

Pregnancies: Number _________

Worsening Psychiatric Symptoms During or After Pregnancy: Yes _____ No _____ N/A _____

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Medical Conditions:

Diagnosis	Date identified	Treatment

Past Surgeries:

Procedure	Date	Hospital	Outcome

Past Medical Hospitalizations:

Hospital	Dates Inpatient	Reason for Admission	Outcome

USF Mood & Anxiety Disorders Program

Past Psychiatric Hospitalizations:

Hospital	Dates Inpatient	Reason for Admission	Outcome

Past Suicide Attempts: Number _____

Date	Method	Hospitalized (Y/N)	Outcome

Current Psychiatric Diagnosis (month/year diagnosed):

____

____

Past Psychiatric Diagnosis (month/year diagnosed):

____

____

Psychotherapy:

Clinician	Type of Therapy	Started	Stopped	Outcome

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Previous Psychiatric Medications:

Medication	Ever Taken		6+ weeks at minimum dose?			Duration
Citalopram or CELEXA	Yes	No	40 mg	Yes	No	___________
Escitalopram or LEXAPRO	Yes	No	20 mg	Yes	No	___________
Fluoxetine or PROZAC, SARAFEM	Yes	No	40 mg	Yes	No	___________
Fluvoxamine or LUVOX	Yes	No	150 mg	Yes	No	___________
Paroxetine or PAXIL	Yes	No	40 mg	Yes	No	___________
Paroxetine CR or PAXIL CR	Yes	No	37.5 mg	Yes	No	___________
Sertraline or ZOLOFT	Yes	No	150 mg	Yes	No	___________
Desvenlafaxine or PRISTIQ	Yes	No	50 mg	Yes	No	___________
Duloxetine or CYMBALTA	Yes	No	90 mg	Yes	No	___________
Milnacipran or SAVELLA, IXEL	Yes	No	100 mg	Yes	No	___________
Venlafaxine XR or EFFEXOR XR	Yes	No	225 mg	Yes	No	___________
Bupropion or WELLBUTRIN, ZYBAN	Yes	No	300 mg	Yes	No	___________
Mirtazapine or REMERON	Yes	No	30 mg	Yes	No	___________
Nefazodone or SERZONE	Yes	No	300 mg	Yes	No	___________
Nomifensine or MERITAL	Yes	No	150 mg	Yes	No	___________
Trazodone or DESYREL	Yes	No	300 mg	Yes	No	___________
Vilazodone or VIIBRYD	Yes	No	40 mg	Yes	No	___________
Amitriptyline or ELAVIL	Yes	No	150 mg	Yes	No	___________
Amoxapine or MOXADIL	Yes	No	150 mg	Yes	No	___________
Clomipramine or ANAFRAMIL	Yes	No	150 mg	Yes	No	___________
Desipramine or NORPRAMINE	Yes	No	150 mg	Yes	No	___________
Doxepin or SINEQUAN, SILENOR	Yes	No	150 mg	Yes	No	___________
Imipramine or TOFRANIL	Yes	No	150 mg	Yes	No	___________
Maprotiline or LUDIOMIL	Yes	No	150 mg	Yes	No	___________
Nortriptyline or PAMELOR	Yes	No	75 mg	Yes	No	___________
Protriptyline or VIVACTIL	Yes	No	30 mg	Yes	No	___________
Trimipramine or SURMONTIL	Yes	No	150 mg	Yes	No	___________
Isocarboxazid or MARPLAN	Yes	No	30 mg	Yes	No	___________
Tranylcypromine or PARNATE	Yes	No	40 mg	Yes	No	___________

Phenelzine or NARDIL	Yes	No	90 mg	Yes	No	___________
Selegiline or Emsam	Yes	No	6 mg	Yes	No	___________

Medication	**Ever Taken**		**Dose**	**Duration**
Carbamezapine or TEGRETOL	Yes	No	___________	___________
Lamotrigine or LAMICTAL	Yes	No	___________	___________
Lithium or LITHOBID	Yes	No	___________	___________
Topiramate or TOPAMAX	Yes	No	___________	___________
Valproic Acid or DEPAKOTE	Yes	No	___________	___________
Aripiprazole or ABILIFY	Yes	No	___________	___________
Asenapine or SAPHRIS	Yes	No	___________	___________
Clozapine or CLOZARIL	Yes	No	___________	___________
Iloperidone or FANAPT	Yes	No	___________	___________
Quetiapine or SEROQUEL	Yes	No	___________	___________
Olanzapine or ZYPREXA	Yes	No	___________	___________
SYMBYAX	Yes	No	___________	___________
Paliperidone or INVEGA	Yes	No	___________	___________
Risperidone or RISPERDAL	Yes	No	___________	___________
Ziprasidone or GEODON	Yes	No	___________	___________
Alprazolam or XANAX	Yes	No	___________	___________
Chlordiazepoxide or LIBRIUM	Yes	No	___________	___________
Clonazepam or KLONOPIN	Yes	No	___________	___________
Diazepam or VALIUM	Yes	No	___________	___________
Lorazepam or ATIVAN	Yes	No	___________	___________
Temazepam or RESTORIL	Yes	No	___________	___________
Buspirone or BUSPAR	Yes	No	___________	___________
Liothyronine or CTOMEL, T3	Yes	No	___________	___________
Modafinil or PROVIGIL	Yes	No	___________	___________
Pemoline or CYLERT	Yes	No	___________	___________
Pindolol or VISKEN	Yes	No	___________	___________
Pramipexole or MIRAPEX	Yes	No	___________	___________

Prazosin or MINIPRESS	Yes	No	___________	___________
Dexmethylphenidate or FOCALIN	Yes	No	___________	___________
Methylphenidate or RITALIN	Yes	No	___________	___________
Methylphenidate XR or CONCERTA	Yes	No	___________	___________
Amphetamine or ADDERALL	Yes	No	___________	___________
Dextroamphetamine or DEXEDRINE	Yes	No	___________	___________
Dextromethamphetamine or DESOXYN	Yes	No	___________	___________
Lisdexamphetamine or VYVANSE	Yes	No	___________	___________

Other Psychiatric Medications	**Reason for Taking**	**Dose**	**Duration**
______________________________	_______________________	______	___________
______________________________	_______________________	______	___________
______________________________	_______________________	______	___________
______________________________	_______________________	______	___________
______________________________	_______________________	______	___________
______________________________	_______________________	______	___________
______________________________	_______________________	______	___________

Previous Brain Stimulation Treatments (ECT, rTMS, VNS, DBS, tDCS, EpCS):

Treatment	Facility	Dates	No. of Treatments	Outcome (improvement/side effects)

Social History

Marital Status:

Single ______

Married _____ time(s) on date(s) ____

Divorced _____ time(s) on date(s) ____

Widowed _____ time(s) on date(s) ____

Children ___ No ____ Yes ____ Number

Ages ____

Siblings (brothers/sisters): ___ Yes ____ No

Ages ____

Education:

Years of Schooling ______ (e.g. graduated high school = 12 years)

Degrees Obtained ____

Current Occupation:

Position Date started

____

____

Previous Occupations:

Position Date started Date stopped Reason stopped

____

____

____

Current Living Situation: ____

Weapons in the Home: No ____ Yes (type) ____________________________________

Do you exercise? No ____ Yes (type) ____________________________________

What is the form of exercise, how many times a week, and for how many minutes?

____

____

Traumatic Events in Life:

Event Date Degree of Impact

____

____

____

____

____

____

Do you use …?

Tobacco no ___ yes ___ started __________ amount ______________ stopped __________

Caffeine no ___ yes ___ started __________ amount ______________ stopped __________

Alcohol no ___ yes ___ started __________ amount ______________ stopped __________

Withdrawal symptoms? no ___ yes ___ symptoms ____________________________

Marijuana no ___ yes ___ started __________ amount ______________ stopped __________

Heroine no ___ yes ___ started __________ amount ______________ stopped __________

Cocaine no ___ yes ___ started __________ amount ______________ stopped __________

Hallucinogens no ___ yes ___ started __________ amount ______________ stopped __________

Other ___________________ started __________ amount ______________ stopped __________

Current Sources of Stress:

____

____

____

Leisure Activities:

____

____

____

Family History: Does a relative related to you by blood have any of the conditions below?

Diagnosis List Relationship after Diagnosis

Depression: ____

Bipolar Disorder: ____

Schizophrenia: ____

Anxiety Disorder: ____

Social Phobia: ____

Post Traumatic Stress Disorder: ____

Panic Disorder: ____

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Eating Disorder (Anorexia or Bulimia): ____

Attention Deficit/Hyperactivity Disorder: ____

Dementia/ Alzheimer's Disease: ____

Alcohol Dependence: ____

Drug Dependence: ____

Impulse Control Disorder: ____

Personality Disorder (e.g., Paranoid, Borderline, Antisocial, Avoidant): ______________________

Committed Suicide: ____

Seizure Disorder: ____

Cerebrovascular Disease (e.g., stroke): ____

Multiple Sclerosis: ____

Brain Tumor: ____

Other Neurologic Conditions (list): ____

____

Endocrine Disorders: ____

Please list any questions you would like to ask your provider at USF Department of Psychiatry and Neurosciences

____

____

____

____

____

____

____

____

Signature of person completing form: ______________________________ **Date:** ________

Print name of person completing form: ______________________________