Brian Buggie, MD ● 445 West 23rd Street, Suite 1EE ● NYC 10011 ● 646-580-8839

Date _____

Health Questionnaire

Patient's Name

Date of Birth Gender

Address

City State ZIP

Home Phone Cell Phone

Work Phone Email

Emergency contact Phone

Address Relationship to you

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Other

Occupation Employer, # of years

Education major or training emphasis Years of Education

Current Living Situation ☐ alone ☐ with spouse/mate ☐ with parents ☐ other:

Spouse/partner name Spouse/partner occupation

Children: ☐ Yes ☐ No Children: ☐ Yes ☐ No Names & Ages: (Please answer below.)

1. 2. 3.

Primary Care Physician: Phone

Psychiatrist: Phone

Therapist: Phone

Pharmacy: Phone

Referred by: Phone

How did you hear about my practice? (friend, therapist, doctor, web, etc.) _____

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MENTAL HEALTH HISTORY

Reason for Consultation:

Goals for treatment:

Have you ever seen a mental health provider for any reason (psychiatrist, psychologist, etc.)? ☐ Yes ☐ No
(If yes, when and why?)

Name and Profession	Type of Treatment (meds, therapy, both)	Reason for Treatment	Reason for Termination	Dates

Have you ever been psychiatrically hospitalized? ☐ Yes ☐ No
(If yes, please provide more information.)

Hospital & Doctor's Name	Reason for hospitalization	Dates

Have you ever had any thoughts of suicide? ☐ Yes ☐ No
Have you ever made a suicide attempt? ☐ Yes ☐ No
If so, when & why?

SYMPTOM SCREEN

Have you ever been sad or depressed for more than two weeks? ☐ Yes ☐ No
Have you ever had so much energy that you didn't need to sleep, and made big plans or bad decisions? ☐ Yes ☐ No
Have you ever been so anxious that you couldn't do anything, or even leave the house? ☐ Yes ☐ No
Do you often feel that you need to count, check or clean things in a special way? ☐ Yes ☐ No
Do you ever have several minutes of extreme anxiety and fear that comes out of the blue? ☐ Yes ☐ No
Do you ever feel that you can't control your thoughts or that people can read or control your mind? ☐ Yes ☐ No
Have you ever thought about someone so much that you followed them? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No

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MEDICAL HISTORY

Do you have any medical illnesses? ☐ Yes ☐ No
(If yes, please list.)

Allergies to any foods or medications? ☐ Yes ☐ No
(If yes, please describe.)

MEDICATIONS

List your current and past prescribed medications and over-the-counter drugs such as vitamins and herbal supplements.

Medication	Dose	Dates taken	Effectiveness	Side Effects	Reason for stopping

HEALTH HABITS

Exercise ☐ Sedentary (No exercise) ☐ Mild exercise (i.e. climb stairs, walk 3 blocks)
☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min.)
☐ Regular vigorous exercise (i.e. work or recreation 4x/week for 30 minutes)

Caffeine ☐ None ☐ Coffee ☐ Tea ☐ Soda _____ # of cups/cans per day

Do you drink alcohol? ☐ Yes ☐ No (If yes, what kind?) _____
How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you ever experienced blackouts? ☐ Yes ☐ No
Are you prone to "binge" drinking? ☐ Yes ☐ No
Have you received treatment for drug or alcohol addiction? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No
☐ Cigarettes _____ #/day ☐ other _____ _____ # of years, or year quit _____

Do you currently use recreational or street drugs? ☐ Yes ☐ No
☐ Cocaine ☐ Heroin ☐ Ecstasy ☐ PCP ☐ Amphetamine ☐ Marijuana ☐ GHB ☐ LSD ☐ Bath Salts

If yes, describe use and frequency. _____

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FAMILY MENTAL HEALTH HISTORY

Any family members with mental or emotional problems? ☐ Yes ☐ No (If yes, please list and describe.)

SOCIAL HISTORY

Where were you born and raised? _____
Did you develop normally as a child? (physically and mentally) ☐ Yes ☐ No
Did you have any problems in school? (discipline or behavioral) ☐ Yes ☐ No

Please check any of the following that applied to your childhood (please describe below):

☐ Hyperactivity	☐ Conduct problems	☐ Sleep walking	☐ Fears/worries
☐ Unhappy childhood	☐ Learning difficulties	☐ Night terrors	☐ Stammering
☐ Happy childhood	☐ Head injury	☐ Abuse: (☐ physical ☐ emotional ☐ sexual)	

Interests and hobbies

Education History

Work History

Relationship History

Sexual Orientation

LEGAL HISTORY

Have you ever been arrested? ☐ Yes ☐ No (If yes, please describe.)

Check if you have been involved in any of the following:

☐ Personal injury litigation ☐ Workers Compensation claims ☐ Bankruptcy
☐ Sexual Harassment complaints ☐ Any professional/administrative complaints
☐ Termination/suspension from a professional society or managed care/insurance panel

MISCELLANEOUS

Any other information that you feel would be helpful? _____