Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
PSYCHIATRY HISTORY QUESTIONNAIRE

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Date: _____

Why are you coming to UW Health Psychiatry and did someone refer you to us?

_____

Psychiatry History:

Have you ever been diagnosed with a psychiatric or mental health disorder? ☐ Yes ☐ No

Depression	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No	Schizoaffective Disorder	☐ Yes	☐ No
Panic Disorder	☐ Yes	☐ No	Psychosis	☐ Yes	☐ No
Social Anxiety Disorder	☐ Yes	☐ No	Attention Deficit/Hyperactive Disorder	☐ Yes	☐ No
Obsessive Compulsive Disorder (OCD)	☐ Yes	☐ No	Learning Disorder	☐ Yes	☐ No
Post Traumatic-Stress Disorder (PTSD)	☐ Yes	☐ No	Autism Spectrum Disorder	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Borderline Personality Disorder	☐ Yes	☐ No
Addiction of any kind	☐ Yes	☐ No	Dementia	☐ Yes	☐ No

Please list any additional psychiatric medication that you have taken in the past: _____

_____

Which of the following psychiatric treatments have you had in the past? Outpatient therapy, psychiatry visits, partial hospital program, residential treatment, hospitalizations, TMS, ECT, ketamine): _____

_____

If hospitalized in the past, please explain: _____

_____

Please list your previous providers: _____

_____

Family Psychiatric History

Have any of your family members been diagnosed with a mental health disorder or attempted suicide? Please explain:

_____

_____

Medical History

Current or chronic illnesses: _____

_____

Please list current medications and doses, including over the counter medications, herbs, and vitamins:

_____

_____

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Allergies and reaction: _____

Do you use tobacco products and if so, how much? _____

How often and what kind of caffeinated beverages do you use? _____

How many beers, glasses of wine, mixed drinks or shots do you typically have in an average week? _____

Have you ever felt that you need to cut down on your drinking? ☐ Yes ☐ No

Have people criticized your drinking? ☐ Yes ☐ No

Have you ever felt guilty about your drinking? ☐ Yes ☐ No

Have you ever felt a need to have a drink in the morning to steady your nerves? ☐ Yes ☐ No

Have you ever had a DWI? ☐ Yes ☐ No

Are you currently involved in any legal problems? ☐ Yes ☐ No If yes, please explain: _____

_____

Social History:

Where did you grow up and explain your family of origin (parents, siblings) and briefly describe your childhood:

_____

_____

_____

_____

Have you been a victim of abuse? ☐ Yes ☐ No _____

Current living situation: _____

Do you feel safe in your current living situation? ☐ Yes ☐ No _____

Marital history and number and ages of children if applicable: _____

Education and current employment: _____

Current support systems: _____

Please list any additional information that you think I should know or that you would like to discuss at today's visit:

_____

What are your goals for psychiatric treatment? _____

_____

Signature of Patient/Representative: _____ Date: _____/_____/_____Time: _____
If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
  ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: _____/_____/_____Time: _____