Paul P. Roberts, M.D.
Psychiatry

Clinical History

Please bring completed form to your first appointment

Name: _____ Date: _____

Your primary care physician: _____

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Please list all drugs that you can't tolerate: _____

_____

Please list here or on an attached page all drugs you currently take, with dose:

_____ _____

_____ _____

_____ _____

_____ _____

Please list psychiatric meds you've taken in the past:

Medication	**Effect and side effects**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list present and past mental health providers, starting with current or most recent:

_____

_____

_____

_____

Past psychiatric hospitalizations:

Facility, location	Involuntary?	Reason for admission	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any past suicide attempt? Circle one: Yes No
Is substance use a present problem? Yes No
Has it been a problem in the past? Yes No
Approximate times per week of marijuana/cannabis use—circle one:
Less than one One to two Three to four Five or more
History of DUI? Yes No
Any other past criminal conviction? Yes No

.....

Please list any mental health problems (diagnoses, hospitalizations, addictions, suicides, etc.) in your parents, grandparents, siblings, or children:

_____

_____

_____

_____

.....

Please list present or past significant health problems:

[ ] Fevers, sweats, weight loss or gain _____
[ ] Recent or upcoming surgery _____
[ ] Headaches _____
[ ] Fainting or loss of consciousness _____
[ ] Seizures or epilepsy _____
[ ] Loss of memory or attention _____
[ ] Tremor, tics, or movement disorder _____
[ ] Change in vision _____
[ ] Change in hearing _____
[ ] Palpitations or arrhythmia _____
[ ] Asthma, COPD, or breathing problem _____
[ ] Kidney disease _____
[ ] Nausea, vomiting, diarrhea, or constipation _____
[ ] Rash or hair loss _____
[ ] Arthritis _____
[ ] Sexual dysfunction or problems _____
[ ] Pregnant or might become pregnant _____
[ ] _____
[ ] _____