



Michael O. Tanzer, MD 65 Broadway, Suite 739, New York, NY 10006

# Health Questionnaire

**Instructions:** Please complete the following information thoroughly and as detailed as possible. This will be respected *as confidential information to be used only for the purpose of gathering valuable history, and making decisions regarding diagnosis and treatment* in the event you are seen by the psychiatrist. Withholding information or failure to offer accurate responses to this inquiry may compromise our ability to treat you effectively. Please complete the entire form using N/A (non-applicable) appropriately.

1. What is the purpose of your visit today? \_\_\_\_\_

2. List medication allergies: \_\_\_\_\_

3. List all prescription medications and how taken (i.e. levothyroxine 75mcg once daily)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. List all herbal supplements and/or over the counter medications

\_\_\_\_\_  
\_\_\_\_\_

**(FEMALES ONLY)**

Are you pregnant or do you have reason to believe you are? **YES NO**

**If so, how many weeks?** \_\_\_\_\_

Are you taking folic acid and prenatal vitamins? **YES NO**

Are you breastfeeding or plan to do so in the near future? **YES NO**

**If so, but not currently, when?** \_\_\_\_\_

To the best of your knowledge are you currently able to bear children? **YES NO**

**If not, please explain** \_\_\_\_\_

Are you currently taking any method of birth control? **YES NO**

**If so, what method(s)** \_\_\_\_\_

Have you taken OR are you taking other measures to avoid pregnancy? **YES NO**

**If so, what measure(s)** \_\_\_\_\_

Are you currently planning pregnancy or in the near future? **YES NO**

**If so, but not currently, when?** \_\_\_\_\_



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Have you ever been admitted to an inpatient psychiatric or substance abuse facility?

YES NO

If so, please provide details below

Facility Name and Location	Year/Length of Stay	Reason for Admission
	/	
	/	
	/	
	/	
	/	
	/	
	/	

Have you ever received electro-convulsive (shock) therapy?

YES NO

Have you ever experienced any of the below while taking any past or currently prescribed medications?

YES NO

If YES, check apply and give name of the medication(s)

- Tremors \_\_\_\_\_
- Seizures \_\_\_\_\_
- Insomnia \_\_\_\_\_
- Dizziness/light headedness \_\_\_\_\_
- Involuntary muscular movements \_\_\_\_\_
- Skin Rash \_\_\_\_\_
- Sexual Dysfunction \_\_\_\_\_
- Elevated blood pressure \_\_\_\_\_
- Heart Palpitations \_\_\_\_\_
- Severe anxiety \_\_\_\_\_
- Severe nausea \_\_\_\_\_
- Diarrhea \_\_\_\_\_
- Constipation \_\_\_\_\_
- Nightmares \_\_\_\_\_
- Toxicity \_\_\_\_\_
- Abnormal labs (i.e. liver enzymes) \_\_\_\_\_



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**PERSONAL NEUROLOGICAL MEDICAL HISTORY** (Please check all that apply)

- Multiple Sclerosis
  - Thyroid Disease
  - Migraine Headaches
  - Tension Headaches
  - Dementia
  - Head/Brain Trauma
  - Other \_\_\_\_\_
  - Seizure Disorder
  - Sleep Apnea
  - Huntington’s Disease
  - Pick’s Disease
  - Brain Tumor
  - Narcolepsy
- 

**PERSONAL MEDICAL HISTORY** (Please check all that apply)

- Stroke
  - Diabetes
  - High Cholesterol
  - Cancer (type \_\_\_\_\_)
  - Heart Attack
  - Sickle Cell Anemia
  - Iron Deficiency Anemia
  - Porphyria
  - Mitral Valve Prolapse
  - Other \_\_\_\_\_
  - Hypertension
  - Asthma
  - Heart Disease
  - Fainting Spells
  - GERD/Heartburn/Stomach Ulcers
  - Irritable Bowel Syndrome
  - Lupus
  - HTV/AIDS
  - Glaucoma/Cataracts
- 

**FAMILY MEDICAL HISTORY** (Please check all that apply)

- Stroke
  - Diabetes
  - High Cholesterol
  - Thyroid Disease
  - Huntington’s Disease
  - Pick’s Disease
  - Other \_\_\_\_\_
  - Hypertension
  - Multiple Sclerosis
  - Heart Disease
  - Sleep Disorder
  - Lupus
- 

**PERSONAL PSYCHIATRIC HISTORY** (Please check all that apply)

- Clinical depression
  - Bipolar (manic-depression)
  - Panic Attacks
  - Agoraphobia
  - Social Anxiety Disorder
  - Anorexia Nervosa
  - Suicide Attempt(s)
  - Suicidal Thoughts
  - Borderline Personality
  - Other \_\_\_\_\_
  - Schizophrenia
  - Schizoaffective Disorder
  - Obsessive-Compulsive Disorder
  - Post Traumatic Stress Disorder
  - Generalized Anxiety Disorder
  - Bulemia Nervosa
  - ADD/ADHD
  - Dissociative Identity Disorder  
(Multiple Personality Disorder)
-



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- Panic Attacks
- Agoraphobia
- Social Anxiety Disorder
- Insomnia
- Other \_\_\_\_\_
- Schizophrenia
- Schizoaffective Disorder
- Obsessive-Compulsive Disorder
- Alzheimer’s Dementia
- Generalized Anxiety Disorder
- Completed Suicide

**ALCOHOL/DRUG CONSUMPTION INQUIRY**

1a. Have you consumed alcohol in the past? **YES NO**  
If so, when was your last drink? \_\_\_\_\_

**Describe your frequency below:**

- Daily
- Weekends
- Binge Drinking
- Occasionally, no more than twice / month
- 1-2 days / week
- 3-4 days / week
- 5-6 days / week .
- Rarely, holidays/special occasions

1b. Describe the amount, type of alcohol, and proof (i.e two mixed drinks w/80 proof Vodka)  
\_\_\_\_\_

1c. Do you sometimes have a drink when you wake from sleeping? **YES NO**

1d. Do you get annoyed when friends/family encourage you to stop drinking? **YES NO**

1e. Have you tried to cut back without much success? **YES NO**

1f. Do you feel guilt sometimes when you drink? **YES NO**

2. Have you ever experienced withdrawal from alcohol or any other drug that caused shakes, anxiety, palpitations, insomnia, cold sweats, muscle cramps, excessive sweating or a seizure while either decreasing your consumption or quitting abruptly ('cold turkey')? **YES NO**

3. When and how long was your longest period of sobriety? \_\_\_\_\_  
\_\_\_\_\_

4. In you opinion, what helped you stay sober? \_\_\_\_\_  
\_\_\_\_\_



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5. Do you attend AA and/or some other type of rehab currently? YES NO
If so, give details \_\_\_\_\_

6. Have you consumed any of the below in the past? YES NO
Marijuana Heroin
Cocaine Inhalants ('huffing or sniffing')
Amphetamine PCP/LSD
Ecstasy Xanax/Xanax bars\*
Other \_\_\_\_\_

If so, describe your frequency below:

- Daily 1-2 days / week
Weekends 3-4 days / week
Binge Drinking 5-6 days / week
Occasionally, no more than twice / month Only as prescribed by my physician

\* Xanax® (alprazolam) is an FDA-approved drug that is often prescribed for anxiety disorders. It is highly effective in the management of acute anxiety and a safe drug that I endorse and prescribe. Unfortunately, some individuals who choose to misuse this drug either by taking unapproved prescribed doses or by obtaining it by some other means and using it for recreational use can become addicted.

HISTORY OF VICTIMIZATION

Have you ever been a victim of physical, emotional, or sexual abuse? YES NO
Have you ever been a victim of molestation, rape, or sexual assault? YES NO
Have you ever been a victim of spousal or relationship abuse? YES NO
Have you ever been involved in military combat, gang violence, riot or a witness of any other violent acts? YES NO
Have you been traumatized by any other witnessed event? YES NO
As a result of your above experience, have you experienced these? YES NO

If so, check all that you experienced

- Flashbacks
Recurrent disturbing memories/thoughts
Nightmares
Panic Attacks
Avoidance of anything that reminds you of the event(s)
Insomnia
Social and/or Occupational dysfunction



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**SYMPTOM CHECKLIST**

Have you felt sad, depressed, or even anxious lately?

If so, **check all you have experienced**

- Sleep disturbance
- Poor energy
- Decreased motivation
- Poor concentration
- Short-term memory problems
- Hopelessness
- Low self-esteem
- Social isolation
- Crying spells
- Irritable
- Poor task completion
- Paranoia
- Auditory hallucinations "hearing voices"
- Visual hallucinations "seeing things"
- Thoughts of self-harm
- Suicidal thoughts
- Homicidal thoughts
- Social and/or Occupational dysfunction
- Decreased libido
- Poor appetite
- Increased appetite
- Easily fatigued
- Low interest in pleasurable things
- Negative thinking
- Guilt/shame/embarrassment
- Feelings of emptiness
- Poor frustration tolerance
- Mood swings
- Panic (anxiety) attacks
- Suspicious of others
- Racing thoughts
- Rapid speech
- Feelings of grandiosity
- Excessive energy "feeling wired"
- Impulsive/risky behaviors
- Other

How long have you experienced these above symptoms? \_\_\_\_\_

List three **recent major life stressors** that could have led to these symptoms

A. \_\_\_\_\_

B. \_\_\_\_\_

C. \_\_\_\_\_

What are your concerns about having these symptoms? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How have these symptoms affected your daily life lately? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_