MOT 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
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Huntington's Disease
- ☐ Pick's Disease
- ☐ Brain Tumor
- ☐ Narcolepsy
- ☐ Other _____

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
- ☐ Hypertension
- ☐ Asthma
- ☐ Heart Disease
- ☐ Fainting Spells
- ☐ GERD/Heartburn/Stomach Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ HTV/AIDS
- ☐ Glaucoma/Cataracts
- ☐ Other _____

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

- ☐ Stroke
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Huntington's Disease
- ☐ Pick's Disease
- ☐ Hypertension
- ☐ Multiple Sclerosis
- ☐ Heart Disease
- ☐ Sleep Disorder
- ☐ Lupus
- ☐ Other _____

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
- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Post Traumatic Stress Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Bulemia Nervosa
- ☐ ADD/ADHD
- ☐ Dissociative Identity Disorder (Multiple Personality Disorder)
- ☐ Other _____

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

☐ Clinical depression
☐ Bipolar (manic-depression)
☐ Panic Attacks
☐ Agoraphobia
☐ Social Anxiety Disorder
☐ Insomnia
☐ Schizophrenia
☐ Schizoaffective Disorder
☐ Obsessive-Compulsive Disorder
☐ Alzheimer's Dementia
☐ Generalized Anxiety Disorder
☐ Completed Suicide

Other _____

ALCOHOL/DRUG CONSUMPTION INQUIRY

la. 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

lb. Describe the amount, type of alcohol, and proof (*i.e two mixed drinks w/80 proof Vodka*)

_____

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

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

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

lf. 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? _____

_____

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
☐ Cocaine
☐ Amphetamine
☐ Ectasy
☐ Heroin
☐ Inhalants ('huffing or sniffing')
☐ PCP/LSD
☐ Xanax/Xanax bars*

Other _____

If so, 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
☐ 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? _____

_____

_____

MOT

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HIPAA Privacy Policies

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) provides certain privacy rights concerning disclosure of a patient's health information. I understand that my information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I may request in writing restrictions as to how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent in writing at any time, except to the extent that action has previously been taken action relying on this consent.

Patient's signature: Date signed:

MOT

Michael O Tanzer, MD 65 Broadway, Suite 739, New York, NY 10006
(646) 580-1970 ~ michael@tanzermd.com

Medical Release Form

Date: _____

By signing this authorization, I authorize Michael Tanzer, M.D. to receive/use and/or disclose the following protected health information (PHI) about me to:

(Name of entity to receive this Information)

(Address of entity to receive this Information)

Phone:Fax:

For the purpose of _____
(ie. Continuity of care, at the request of the individual, disability, employment, etc)

This authorization permits Michael Tanzer, MD. to receive/use and/or disclose the following individually identifiable health information about me

( ) Any psychiatric information including notes, diagnosis, dates of service, etc.

( ) Summary report of psychiatric treatment

( ) Complete Medical/Psychiatric record (written/verbal documentation) including urinary drug screen results.

( ) Other (please specify) _____

I release you from all legal responsibilities or liabilities that may arise from this authorization. This authorization expires on_____(**unless there is a date written in the space provided, THIS RELEASE is valid for one year from the date printed below**). When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I do not have to sign this authorization to obtain treatment.

If this form is a release for Dr. Tanzer to give information about me to a new therapist or doctor, I give that therapist or doctor permission to call me to arrange the first appointment.

No ☐ Yes ☐ Patient's Initials_____Contact Number _____

_____ _____

Signature of patient or legal guardian Date

_____

(Patient Name- Please print)

Signature witnessed by:_____Date:_____

To revoke this authorization you must submit a request in writing to the address above.

Financial Agreement

This form authorizes Michael O. Tanzer, MD, 65 Broadway, Suite 739, New York, NY 10006 to bill my credit card for office visits. It is understood that I will also be billed for missed appointments that have not been canceled 48 prior to a scheduled session or in the event of non-payment of a bill or past due balances.

Patient's Name:
Name on Credit Card:
Credit Card (Amex, MasterCard or Visa):
Card Number:
Expiration Date:
CVV Number (3 or 4 digits):
Patient's Address:
Signature:
Date: