

PATIENT INFORMATION

NAME (First, Middle, Last)

HEIGHT

WEIGHT

Reason for today's visit:

Medication allergies (symptoms of allergic reaction):

Current prescription and over-the-counter medications (provide doses, if possible):

Past medications tried for treatment of a mental health condition or insomnia (doses, if you recall):

Primary Care Physician

NAME

ADDRESS

PHONE NUMBER

Current Psychiatrist (if applicable)

NAME

ADDRESS

PHONE NUMBER

Current Therapist

NAME

EMAIL

ADDRESS

PHONE NUMBER

Medical conditions you have been treated for:

Psychiatric hospitalizations (reason, location, and dates if possible):

Suicide attempts (dates, if possible):

Substance use disorder treatment (dates and location, if possible):

Family history of psychiatric illness (please list family member and known diagnosis):

Please look at the list of physical symptoms below and check off any that you have experienced in the last SEVERAL DAYS:

- | | | |
|---|--|--|
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Painful/Burning urination |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Pacemaker placement | <input type="checkbox"/> Urine retention |
| <input type="checkbox"/> Increase in appetite | <input type="checkbox"/> Palpitations
(fast or irregular heartbeat) | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Swollen feet or hands | <input type="checkbox"/> Short-term memory difficulties |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Fatigue/Lethargy | <input type="checkbox"/> Shortness of breath with mild exercise | <input type="checkbox"/> Numbness/Tingling sensations |
| <input type="checkbox"/> Unexplained fever | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Tremors in hands/shaking |
| <input type="checkbox"/> Hot or cold spells | <input type="checkbox"/> Chronic shortness of breath | <input type="checkbox"/> Muscle spasms or tremors |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Chronic wheezing/Asthma | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Sleeping pattern disruption | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Hair or nail changes |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Blurred or double vision | <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Feeling depressed |
| <input type="checkbox"/> Visual change | <input type="checkbox"/> Persistent nausea or vomiting | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Retinal hemorrhage
(floaters in vision) | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Phobias/Unexplained fears |
| <input type="checkbox"/> Tinnitus (ringing in ears) | <input type="checkbox"/> Frequent heartburn (GERD) | <input type="checkbox"/> No pleasure from life anymore |
| <input type="checkbox"/> Decreased hearing or hearing loss | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Panic attacks or frequent anxiety |
| <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Dark/Tarry stools | <input type="checkbox"/> Frequent insomnia |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Excessive moodiness |
| <input type="checkbox"/> Teeth grinding/clenching at night | <input type="checkbox"/> Hives | <input type="checkbox"/> Confusional states |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Cold or heat intolerance | <input type="checkbox"/> Frequent nightmares |
| <input type="checkbox"/> Joint pains or stiffness | <input type="checkbox"/> Excessive thirst or urination | |
| <input type="checkbox"/> Muscle pain or cramping | <input type="checkbox"/> Excessive/Easy bruising | |
| <input type="checkbox"/> Muscle weakness | | |
| <input type="checkbox"/> Back pain or stiffness | | |

CONSENT TO OBTAIN MEDICATION HISTORY

Meridian Psychiatric Partners has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your “medication history.” A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medications to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over-the-counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

- I give permission for Meridian Psychiatric Providers to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.
- I DO NOT give permission for Meridian Psychiatric Providers to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

SIGNATURE

PATIENT NAME

DATE OF BIRTH

PATIENT SIGNATURE

DATE