LEVA PSYCHIATRY
4445 Corporation Lane
Suite 213
Virginia Beach, VA 23462
Phone: 757-453-5508 Fax: 757-216-9655

PATIENT MEDICAL HISTORY FORM

Date: _____ First Name : _____ Last Name: _____ DOB:_____
Age: _____ Gender: ____ Sexual Orientation: _____
Relationship Status: ☐Married ☐Divorced ☐Single ☐Separated
How did you hear about this practice:

Describe briefly your present symptoms:

Sleep: How many hours do you sleep per night? _____
Any problems with: ❑Difficulty falling asleep ❑Waking up in middle of night ❑Nightmares ❑Restless sleep ❑Daytime Fatigue ❑Sleep Apnea ❑ Excessive daytime sleep ❑Narcolepsy ❑Snoring
Sleep Habits: ❑ Watching television at bedtime ❑ Using Ipad/computer/cell phone within 2 hours of going to bed ❑ Caffeine intake in afternoon/evening ❑ Exercise in evenings ❑Use of sleep medications/herbal or homeopathic remedies for sleep

Appetite: ❑Same as before ❑Decreased ❑Increased ❑Dieting

Eating Behaviors: ❑Binging ❑Induced vomiting ❑Laxative use ❑Calorie restriction ❑ Exercise others feel is excessive

Any weight changes: _____ Highest Weight _____ Lowest Weight _____
Energy Level: ❑Same as before ❑Decreased ❑Increased

Reproductive:

How many times have you been pregnant? ____

How many children do you have? _____

Have you ever had any of the following: ❑Miscarriage ❑Fetal loss ❑Death of a child ❑Postpartum depression ❑Postpartum psychosis ❑Postpartum anxiety ❑Postpartum OCD ❑Depression in Pregnancy ❑Birth trauma

Date of Last Menstrual Period: _____ Form of Birth Control_____
Are you trying to get pregnant? _____

Mood Symptoms: (Check)

- ☐ Sadness
- ☐ Insomnia
- ☐ Panic Attacks
- ☐ Obsessions/compulsions
- ☐ Hopelessness
- ☐ Guilt
- ☐ Grief/Loss
- ☐ Racing Thoughts
- ☐ Anxiety
- ☐ Fatigue
- ☐ Eating disorder
- ☐ Memory impairment
- ☐ Withdrawal/decrease socialization
- ☐ Decreased interest levels
- ☐ Irritability/easily angered
- ☐ Aggression
- ☐ Behavioral problems
- ☐ Impulsivity
- ☐ Uncontrolled fear/phobia
- ☐ Nightmares
- ☐ Recollection of Trauma
- ☐ Feeling of Worthlessness
- ☐ Personality changes
- ☐ Development disorder
- ☐ Chronic pain issues
- ☐ General overwhelming stress
- ☐ Thoughts of hurting self
- ☐ Actively plan to hurt myself
- ☐ Hallucinations (hearing voices/seeing things)
- ☐ Difficulty with work/school/family
- ☐ Difficulty motivating myself to do basic responsibilities
- ☐ Rapid weight loss/weight gain
- ☐ Mania (decrease sleep accompanied by very high energy or agitation, impulsivity, increase in goals, drive to do activity)

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PSYCHIATRIC HOSPITALIZATION HISTORY

Have you ever been hospitalized in a psychiatric facility: ❑ Yes ❑ No
If Yes, Name of Hospital(s)_____
Dates of hospitalizations_____
Reason for
hospitalizations_____
_____

PSYCHIATRIC HISTORY

What have you been treated for in the past: (Check)
❑ Major depression ❑ General anxiety disorder ❑ Obsessive compulsive disorder ❑ Bipolar disorder
❑ Schizophrenia ❑ Autism Schizoaffective disorder ❑ Eating disorder ❑ Personality disorder
❑ ADHD/ADD ❑ Post-traumatic stress disorder ❑ Other: _____

Suicide History: History of Suicidal Ideation: ☐ Y or ☐ N
History of suicide attempts: ☐ Y or ☐ N. If Yes, specify : _____
Number of attempts in lifetime: _____ History of self injury: ☐ Y or ☐ N

Trauma History: (check)

- ☐ Childhood Physical Abuse
- ☐ Childhood emotional/verbal abuse
- ☐ Childhood sexual abuse
- ☐ Childhood exposure to domestic violence
- ☐ Neglect in childhood
- ☐ Exposure to war
- ☐ Combat Trauma
- ☐ Early parental loss
- ☐ Forced prostitution
- ☐ Witnessed the death of loved one
- ☐ Survivor of suicide
- ☐ Exposure to potentially deadly/deadly accident
- ☐ Exposure to terrorist act
- ☐ Exposure to fire
- ☐ Exposure to natural disaster
- ☐ Partner physical/emotional/verbal abuse
- ☐ Stranger Rape/Assault
- ☐ Rape/Assault by family member

OUTPATIENT HISTORY

Prior medication trials:
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

Do you now or have ever had:

- ☐ Diabetes
- ☐ Heart murmur
- ☐ Crohn's disease
- ☐ High blood Pressure
- ☐ Pneumonia
- ☐ Colitis
- ☐ High cholesterol
- ☐ Pulmonary embolism
- ☐ Anemia
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Jaundice
- ☐ Goiter
- ☐ Emphysema
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Cancer
- ☐ Stomach or peptic ulcer
- ☐ Stroke
- ☐ Leukemia
- ☐ Cataracts
- ☐ Rheumatic fever
- ☐ Psoriasis
- ☐ Epilepsy (seizures)

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SURGICAL HISTORY:
Please list surgical history and dates:

_____
_____
_____
_____

PREVIOUS/ CURRENT PSYCHIATRIC PROVIDERS:
Name of providers present:

_____
_____
_____

Past treatment providers:

_____
_____
_____

FAMILY HISTORY: Include: Bipolar disorder, anxiety, personality disorders, substance abuse, ADHD/ ADD, Autism, depression, schizophrenia, suicide attempts
Mother-
Father-
Sister-
Brother-
PGM-
PGF-
MGM-

SUBSTANCE USE HISTORY

Substance Used	Frequency of Use	Duration of Use	Adverse Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been treated for substance abuse? ☐Yes ☐No
Have you ever experienced any of the following as a result of your drug or alcohol use?
□ Arrests □ Consuming more than intended □Blackouts □DUI □Employment issues
□ Family/Marital Conflict □ Feeling guilty □Financial problems □ Fighting □ Health Problems
□ Increased Tolerance □ Unintentional Overdose □ Physical Health Problems
□ Seizures □ Withdrawal history

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Are you on Suboxone or Methadone? No

CURRENT MEDICATIONS:

Name of Medication Dosage Condition treated

_____
_____
_____
_____
_____
_____

SOCIAL HISTORY
(FOR CHILDREN AND ADOLESCENTS)

Who lives at home?_____
Are parents married? _____
Are there step-parents involved? _____
School attended: _____
Grade: ____ IEP in place: No 504 in place: No Special ed: No Gifted: No
Other services involved at school? _____
Aggression at school? No Suspension/ Expulsion from school: No Excessive Absences: No
Extracurricular activities:

_____
_____

SOCIAL HISTORY
(FOR ADULTS)

Who lives in the home: _____
Highest level of education: _____
Employment status: ☐ Full-time ☐ Part-time ☐ Unemployed
Occupation: _____ Employer: _____
How long have you had this job?_____
List current stressors:

_____
_____

ADDITIONAL INFORMATION: Please inform me of any other concerns or pertinent information here:

_____
_____
_____
_____
_____
_____