New Psychiatric History Form

Nebraska Lincoln | Nebraska Medicine

Name ______________________ **Preferred name** ______________________

Date of birth ______________________ **Pronouns** ______________________

List your allergies:

____

____

____

____

List your current medications (including birth control, over-the-counter medications, vitamins, etc.):

____

____

____

____

Do you want to use the University Health Center Pharmacy? ☐ Yes ☐ No

If no, what is your pharmacy preference?

____

VACCINE:

Have you had a flu shot this season? ☐ Yes ☐ No

DEPRESSION SCREENING:

Little interest or pleasure in doing things:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed or hopeless:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

NUTRITIONAL SCREENING:

Unintended weight loss or gain of ten pounds or more in the last 3 months?

☐ Yes ☐ No

MEDICAL HISTORY

☐ Other: ______________________

Are you sexually active? ☐ Yes ☐ Not currently ☐ Never **Partners:** ☐ Male ☐ Female ☐ Both

FAMILY HEALTH HISTORY:

	Deceased?	ADHD	Alcohol abuse	Anxiety disorder	Bipolar disorder	Dementia	Depression	Drug abuse	OCD	Paranoid behavior	Schizophrenia	Seizures	Learning disabilities	Clotting disorder	Diabetes	Heart disease	High blood pressure	High cholesterol	Stroke	Sudden cardiac arrest	Cancer	Other health issues
Mother																						
Father																						
Sister																						
Brother																						
Maternal Aunt																						
Paternal Aunt																						
Maternal Uncle																						
Paternal Uncle																						
Maternal Grandfather																						
Paternal Grandfather																						
Maternal Grandmother																						
Paternal Grandmother																						

☐ Adopted ☐ Family history unknown

ABUSE HISTORY:

As violence is a problem in many families, we ask these questions to ALL patients. *Please check all that apply.*

Verbal abuse:
- ☐ Never experienced
- ☐ Experienced in the past
- ☐ Currently experience
- ☐ Choose not to disclose

Physical abuse:
- ☐ Never experienced
- ☐ Experienced in the past
- ☐ Currently experience
- ☐ Choose not to disclose

Sexual abuse:
- ☐ Never experienced
- ☐ Experienced in the past
- ☐ Currently experience
- ☐ Choose not to disclose

ALCOHOL USE:

Do you drink?

☐ Yes ☐ No

If yes, how many per week?

Glasses of wine: ________ Cans of beer: ________ Shots of liquor: ________

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week

How many standard drinks containing alcohol do you have on a typical day?

☐ 0-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

SUBSTANCE ABUSE

Do you currently use? ☐ Yes ☐ No **If yes, how many per week?** ______________________

I use:

☐ Amphetamines	☐ "Crack" cocaine	☐ Hashish	☐ Mescaline	☐ Opiates
☐ Amylnitrate	☐ Cocaine	☐ Ketamine	☐ Methamphetamines	☐ Opium
☐ Anabolic steroids	☐ Fentanyl	☐ LSD	☐ Methaqualone	☐ PCP
☐ Barbiturates	☐ Flunitrazepam	☐ Marijuana	☐ Methylphenidate	☐ Psilocybin
☐ Benzodiazepines	☐ GHB	☐ Ecstasy	☐ Nitrous oxide	☐ Solvent inhalants

☐ Other: ____

TOBACCO USE:

Do you chew tobacco? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many packs a day? ☐ 0.25 ☐ 0.5 ☐ 1 ☐ 2 ☐ 2.5 ☐ 3

E-cigarettes/vape/Juul? ☐ Yes ☐ No

If yes, cartridges per day? ______________________

Start date: ________________ **End date:** ________________ **Ready to quit?** ☐ Yes ☐ No

Years smoked: ________________ **Years vaped:** ________________

Do you use smokeless tobacco?

☐ Never ☐ Former ☐ Current ☐ Unknown

Passive exposure to tobacco?

☐ Yes ☐ No

SEXUAL ORIENTATION/GENDER

What is your sexual orientation?

☐ Straight (not lesbian or gay)	☐ Gay	☐ Bisexual	☐ Choose not to disclose	☐ Something else: ________________
	☐ Lesbian	☐ Don't know		

What is your gender?

☐ Female	☐ Transgender female	☐ Non-binary	☐ Choose not to disclose	☐ Other: ________________
☐ Male	☐ Transgender male			