

DISEASE MANAGEMENT

Date _____ Patient's Name _____

Physician _____ SS# _____

D.O.B. _____

Presenting Symptoms and Complaints

Psychiatric History (Including use of Psychotropic Medications)

| Brief History: (Check all that apply and explain) | | Dates | Inpatient treatment | Outpatient treatment | Antidepressant Medication |
|--|--|-------|---------------------|----------------------|---------------------------|
| Depression | | | | | |
| Anxiety | | | | | |
| Alcoholism | | | | | |
| Other | | | | | |

Drug Allergies _____

Current Medications, Dose and Frequency: (See attached medication list)

Substance Use

Family History of Psychiatric Illness/Treatment

Med/Surg history

Major Life Stressors
