3 East 65th Street
New York, NY 10065
212-570-4052

26 Court Street
Brooklyn Heights, NY 11242
212-570-4052

Patient History Form

Patient Name____ Today's Date_____________

Address____

Cell phone____

Home phone____

E-mail Address____

Date of Birth_________________Age_______

Height_____________ Weight____________

Emergency Contact (name and phone number)_______________________________

Referring Doctor______________________ Family Physician ________________________________

Chief Complaint ____

(Reason for today's visit)

Current Medications	Dose	Frequency

Do you take vitamins, supplements or nutraceuticals? (list name and dosage)

____

____

____

____

Have you taken any aspirin, ibuprofen or arthritis medicine in the last two weeks?____________________

If so, how much, when?______________________________

Do you bruise easily? _________________________

DRUG ALLERGIES:

____
____
____

Psychiatric History:____

Prior Psychiatric Treatment:____

Prior Addiction Treatment: ____

Prior Psychiatric Medication (dates used, doctor who prescribed it, medication, dosage, effect & side-effect)

____
____
____

Medical Illnesses:

____

Hospitalizations

____**Date**________________
____**Date**________________

Surgical Procedures

____**Date**________________
____**Date**________________
____**Date**________________
____**Date**________________

Family History:

Family Member	**Psychiatric Illness, History of Addiction, Medical Illnesses**
Mother	
Grandparents (maternal)	
Father	
Grandparents (paternal)	
Sister(s) / Brother (s)	

Social History:

Are you presently working or going to school full or part time? ______________________________________

Employer / School: ____

Marital Status:_______________ Do you live alone? _________ Who lives with you?____________________

Do you have children?______
If yes, how many? Ages and names of children ____
____
____

Do you smoke cigarettes? __Yes __No (How many cigarettes or packs per day?)___________________
Cigars?____________ Pipe?___________ Chewing tobacco?_________
Marijuana?__________________________
How long have you been chewing or smoking ____________________

Do you drink alcohol? __Yes __ No
Is it __Social __Heavy __Prior addiction?
How many days per week do you drink? _________
How many drinks do you consume in one day? _________
How many drinks do you consume per week (total)? _________

Do you take or have you taken recreational drugs? __Yes __No
___Marijuana?
___Cocaine?
___Amphetamines?
___Opiates?
___Heroin?
___Club Drugs?

Do you have any difficulty sleeping?
__Never __Often __Sometimes __Getting to sleep __Staying awake

What time do you go to sleep? ___________Wake up? ___________

Does anyone complain that you snore? __Yes __ No

Do you stop breathing at night? __Yes __No

Do you wake up tired in the morning? __Yes __ No

Do you fall asleep in the daytime? __Yes __No

Caffeine intake per day: _________________

Do you exercise? __ Yes __No Type/Frequency:______________________________________

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)? _____________
If yes, explain: ____

Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being
__ Fever
__ Weight loss (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes
__ Wear glasses
Date of last exam ______
__ Infections
__ Injuries
__ Glaucoma
__ Cataracts
__ Blurred vision
__ Trouble focusing
__ Recent change in vision

Ears, Nose, Mouth and Throat
__ Wear hearing aids
Date of last exam_______
__ Hearing loss
__ Ear infection
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Balance disturbance
__ Itching in ears
__ Dizziness
__ Nasal congestion
__ Nasal drainage
__ Nosebleeds
__ Sinus problems
__ Sinus infections
__ Sinus headaches
__ Throat infections
__ Difficulty swallowing
__ Lip or mouth sores
__ Sore throats

Respiratory
__ Chronic cough
__ Emphysema
__ Bronchitis
__ Asthma
__ Chronic obstruction
__ Pulmonary disease
__ Shortness of breath
__ Oxygen use at home
__ Pneumonia
__ Lung cancer
__ Tuberculosis
__ Blood in saliva
Date of last chest X-ray__________

Cardiovascular
__ Chest pain
Date of last EKG _______
__ Heart attack
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Heart murmur
__ Arm and leg swelling
__ High cholesterol

Gastrointestinal
__ Blood in vomit
__ Indigestion
__ Nausea / vomiting
__ Jaundice
__ Abdominal pain
__ Change in bowel habits
__ Ulcers or Gastritis
__ Colon, liver, stomach cancer
__ Hepatitis

Hematologic
__ Anemia
__ Hemophilia
__ Easy bleeding / bruising
__ Swollen glands

Genitourinary
__ Urinary tract infection
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Kidney stones
__ Prostate cancer
__ Endometriosis
__ Uterine, ovarian or cervical cancer

Neurological
__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Seizures
__ Stroke
__ Mini-stroke
__ Memory problems
__ Concentration problems
__ Speech problems
__ Facial weakness/ spasms
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine
__ Diabetes
__ Hormone problems
__ Low blood sugar
__ Thyroid disease
__ Increased appetite
__ Excessive thirst
__ Excessive urination
__ Temperature intolerance
__ Pituitary gland problems
__ Bleeding tendencies

Immunologic
__ Environmental allergies
__ Hay fever
__ Food allergies
__ Immune system problems
__ Connective tissue disease
__ Frequent colds / infections

Skin
__ Eczema or psoriasis
__ Dermatitis
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles
__ Skin cancer
__ Breast pain or swelling
Date of last Mammogram
____

Musculoskeletal
__ Broken bones
list:________________
__ Arm or leg weakness
__ Joint pain or swelling
__ Back pain
__ Arthritis

Psychiatric
__ Anxiety
__ Depression
__ Manic/Depression
__ Schizophrenia
__ Considering suicide / homicide
__ Panic attacks
__ Sudden mood swings
__ Emotional difficulties
__ Insomnia

PLEASE GIVE DR. GOLDFARB ANY LABWORK YOU HAVE HAD IN THE PAST YEAR.
YOU MAY REQUEST THAT YOUR DOCTOR FAX IT TO 212 570-1077

The above information is accurate to the best of my knowledge.

____ ______________________
Patient Signature *Date*

I have reviewed the above information with the patient.

____ ______________________
Lisa Goldfarb MD *Date*