Sonia Juneja, M. D.
Patient Medical History Form

Today's Date ___/___/___

Name _____

Date of Birth ___/___/___ Age: ____ Sex: ___Female ___Male

Describe briefly your present symptoms/problems: _____

_____

_____

Please list other practitioners you have seen for this problem: _____

_____

Please provide details regarding any outpatient psychiatric treatment/psychotherapy you may have had in the past: _____

_____

_____

_____

_____

Are you currently in treatment with a mental health professional? _____

Psychiatric Hospitalizations (include where, when, for what reason and psychiatric diagnosis)_____

_____

_____

Drug Allergies: ___ Yes ___ No To What?_____

CURRENT MEDICATIONS

Please list any medications that you are taking now. Include non-prescription medications and vitamins or supplements.

Name of Medication	Dose (strength & number of pills/day)	How long have you been taking?

PAST MEDICAL HISTORY

Do you now or have you ever had:

___ Diabetes
___ High Blood Pressure
___ High Cholesterol
___ Hypothyroidism
___ Goiter
___ Cancer (type)_____
___ Leukemia
___ Psoriasis
___ Angina
___ Heart problems
___ Heart Murmur
___ Pneumonia
___ Pulmonary Embolism
___ Asthma
___ Emphysema
___ Stroke
___ Epilepsy (Seizures)
___ Cataracts
___ Kidney disease
___ HIV/AIDS
___ Crohn's Disease
___ Colitis
___ Anemia
___ Jaundice
___ Hepatitis
___ Peptic ulcer
___ Rheumatic Fever
___ Tuberculosis
___ Liver disease

Other medical Condition (please list) _____

PERSONAL HISTORY

Were there any problems with your birth _____
Where were you born and raised _____
What is your highest education?
____ High School ___ Some College ___ Graduate ___ Advanced Degree
Marital Status: ___ Never Married ___ Married ___ Separated ___Divorced ___ Widowed
___ Partner/Significant other
What is your current or past occupation _____
Are you currently working ___ Yes ___ No Hours/wk. _____
If not, are you: ___ Retired ___ Disabled ____Sick Leave
Do you receive disability or SSI? ___ Yes ___ No
If yes, for what and how long _____
Have you ever had legal problems (specify) _____
_____

FAMILY HISTORY

	If Living		If deceased	
	Age	Psychiatric Condition	Age at death	Cause of Death
Father				
Mother				
Siblings				
Children				

Extended Family Psychiatric Problems – Past or Present:

Maternal Relatives _____

Paternal Relatives _____

SUBSTANCE USE HISTORY

Drug Category	**Age when you first used this**	**How much and how often did u use?**	**How many years did you use?**	**When did you last use this?**	**Do you currently use this?**
ALCOHOL					YES NO
CANNABIS *Marijuana, Hashish, Hash Oil*					YES NO
STIMULANTS *Cocaine, Crack*					YES NO
AMPHETAMINS/STIMULANTS *Ritalin, Dexedrine, Adderall*					YES NO
BENZODIAZEPINES/TRANQUILIZERS *Valium, Librium, Xanax, "Roofies"*					YES NO
SEDATIVES/ HYPNOTICS *Amytal, Seconal, Phenobarbital, Dalmane*					YES NO
HEROIN					YES NO
STREET OR ILLICIT METHADONE					YES NO
OTHER OPIOIDS *Tylenol 2, #3, percodon, Percocet, opium, Demerol, dilaudid,*					YES NO
HALLUCINOGENS *LSD, PCP, STP, MDA, DAT, mushrooms, ecstasy, mescaline*					YES NO
INHALANTS *Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room*					YES NO
OTHER *Specify;*					YES NO