Salvador Leo Cevallos, M.D.
CENTER FOR BEHAVIOR MEDICINE

NEW PATIENT QUESTIONNAIRE - ADULT

Date of Visit:_____

Patient's Name:_____ **DOB:**_____**Age/Sex:**_____

1. **Purpose of Visit: What is the ONE main problem (chief complaint) which caused you to visit us? Please explain in your own words.**

_____

_____

_____

2. **What other problems/concerns do you have that you want to be addressed on this visit?**

_____

_____

_____

3. **Allergies to Medication:**_____

4. **Current Medication/s:** ▫ **None**

Name	Dose and Times Per Day	Length of use	Compliance (G-good, P-poor, PRN-as needed)

5. **Are you taking any over-the-counter medicine/vitamins/ supplements? If yes, please list.**

_____

_____

6. **Are you seeing a therapist or counselor? If yes, please write name and contact number.**_____

7. **Are you currently getting any type of treatment from other providers for your behavior or emotional problem (such as chiropractic, herbal, homeopathic, acupuncture, computer-based training programs, biofeedback, etc)?**_____

_____

_____

8. **Psychotropic Medication Trial History: Please list previous medication/s taken for emotional and behavioral problems.**

Name of Medicine and for what target symptom/s	Highest Dose Given	Estimated date given and for how long	Response (none, fair, good, I do not know) and side effects, if any	Name of Prescriber

9. **Do you have any current medical problems? If so, please list.**

_____

_____

_____

10. **Substance Use History:**
    a. **Do you drink alcohol currently? ( ) Yes ( ) No If so, how much?**_____
    b. **Do you use illicit drugs or narcotics? ( ) Yes ( ) No**
    c. **Do you smoke cigarettes/tobacco? ( ) Yes ( )No If so,_____ packs/day for _____ years**

d. **Do you drink coffee/caffeinated/energy drinks ( ) Yes ( ) No**
   If so, how many cups/bottles day?_____
e. **Do you have any DUI charges or other drug-related charges? ( ) Yes ( ) No**

11. Is there anybody in your family diagnosed with depression, anxiety, ADHD, Bipolar, Schizophrenia or any other psychiatric or mental health problems? If so, please list diagnosis and their relationship to you.

_____

_____

_____

12. Does anyone in your immediate family have any of the following medical conditions?

- o **Diabetes**
- o **High blood pressure problems**
- o **Obesity**
- o **Heart disease**
- o **Epilepsy/seizure disorder**
- o **Thyroid problems**
- o **Kidney disease**
- o **Cholesterol problems**
- o **Sudden death**

13. Social History and Lifestyle Questions:

a. **Marital Status:**
   ( ) Single ( ) Married/In a relationship ( ) Divorced/Separated ( ) Others_____
b. **If married or in a relationship, how is your relationship with your spouse/partner?**
   _____
c. **Do you have any children? ( ) Yes ( ) No If yes, please indicate their ages and genders:**
   _____
d. **Highest educational attainment: _____**
e. **Are you currently employed? ( ) Yes ( ) No If yes, what is your current job?_____**
f. **Are you currently receiving any Social Security benefits for mental health problems?**
   ( ) Yes ( ) No
g. **Do you have any family and/or friends in your community? ( ) Yes ( ) No**
h. **Are you affiliated with a religious organization? ( ) Yes ( ) No**
i. **What are your interests and hobbies? _____**
j. **Do you exercise regularly? ( ) Yes ( ) No**
k. **How would you describe your eating habits? ( ) Poor ( ) Fair ( ) Good**

14. Have you ever served in the Military? ( ) Yes ( ) No

a. **If yes, what branch?** _____
b. **Any combat experience? ( ) Yes ( ) No**
c. **Years of service?** _____
d. **Type of discharge?** _____

15. Did you ever experience any traumatic event/s like being abused or being in a serious accident?

( ) Yes ( ) No

16. Review of Systems: Do you currently have any of the following symptoms? ( ) None

General:	() Sleep problems () Excessive tiredness () Poor appetite () Weight loss () Weight gain () Fainting spells () Involuntary facial/body movements () Muscle aches or stiffness () Skin rash () Itching () Easy bruising/bleeding () Fever () Hot flashes () Tremors/ Shaking () Excessive sweating () Memory problems () Focusing problems Others: _____
HEENT:	() Headaches () Dizziness () Blurred vision/Vision problems () Hearing problems () Ringing in the ears () Vertigo () Sore throat () Hoarseness () Difficulty swallowing () Dry mouth
CV:	() Chest pain/discomfort () Palpitations () Leg swelling () Fast heart rate () High blood pressure
RESP:	() Difficulty breathing () Cough () Frequent colds
GI:	() Nausea () Vomiting () Abdominal pain () Diarrhea () Constipation
GU:	() Difficulty urinating () Frequent urination () Incontinence () Irregular menses () Painful intercourse () Erection problems () Ejaculation problems () Abnormal discharge () Decrease libido

17. Please write down name, address and telephone number of your PHARMACY in case medication/s are to be prescribed:_____