MOOD DISORDER HEALTH HISTORY QUESTIONNAIRE

Last Name: _____ **First Name:** _____ **MI:** _____

DOB: / / **DATE:** / /

Primary Phone #: _____ Alternate Phone #: _____

Email Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relation to Patient: _____

Primary Care Physician Name: _____ Phone #: _____

Psychiatrist Name: _____ Psychiatrist Phone #: _____

Psychiatrist Diagnosis (list all): _____

Psychiatric Medications	Dose	Frequency

Psychiatric Medications Tried But Discontinued: _____

Other Medications:	Dose	Frequency

	Yes	No	
1.	◯	◯	Currently taking benzodiazepines?
2.	◯	◯	Currently taking opiates?

Approx. Height: _____ Approx. Weight: _____

Allergies to Medication: _____

Other Medical Problems: _____

MOOD DISORDER HEALTH HISTORY QUESTIONNAIRE

Last Name: _____ **First Name:** _____

Past Surgical History: _____

Hospitalizations: _____

Psychiatric Hospitalizations: _____

Previous Anesthesia Experience: _____

Any Reactions to Anesthesia: _____

Substance Use	Frequency	For How Many Years?	Last used
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Heroin			
Other			

Family History: _____

Your Occupation: _____

I certify that I have personally completed this form and that this form is accurate and complete to the best of my knowledge.

Patient's Signature _____ Date _____

Patient's Representative (for minors only) _____ Date _____

Relationship of Patient Representative to Patient _____

We are required by law to maintain the privacy of, and provide individuals with, the Notice of our legal duties and Privacy Practices with respect to your Protected Health Information. If you have any objections to this form and/or have any questions regarding this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Also, we have provided you with the Patient Rights and Responsibilities information.

Your signature below is acknowledgement that you have received the Notice of our Privacy Practices, Patient Consent, Patient Responsibilities information.

Date: _____

Print Name: _____ Signature: _____

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