Lakeview TMS Center Patient History

PATIENT: ______________________

DOB: ______________________

DATE: ______________________

Past Psychiatric History

Current Providers: ☐ No ☐ Yes
Therapist:

Psychiatrist:

Past Providers: ☐ No ☐ Yes
Therapist:

Psychiatrist:

Psychological/IQ Testing done ☐ No ☐ Yes; If Yes: when and what where the results

Inpatient Psychiatric Hospitalizations: ☐ No ☐ Yes; If Yes: detail when, where, and why
1. ______________________
2. ______________________
3. ______________________

Day Treatment Hospitalizations: ☐ No ☐ Yes; If Yes: detail when, where, and why
1. ______________________
2. ______________________
3. ______________________

Suicide Attempts ☐ No ☐ Yes; If Yes: detail when, method of attempt, and if medical treatment was sought/ received
1. ______________________
2. ______________________
3. ______________________

Substance Use/ Abuse/ Dependence (Curren/Past): ☐ No ☐ Yes

☐ Nicotine ☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Opiates (Heroin, etc.) ☐ Prescription drugs ☐ IV Drugs ☐ Other ______________________

______ Use Per Week: ______ Date of First Use: ______ Date of Last Use: ______ Withdrawal Symptoms: ☐ No ☐ Yes

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List ALL Current Medications- including herbal, supplements, over the counter	Dose	Frequency	Route
Who has been prescribing the above medications?			

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Past Medical History

Medication Allergies ☐ No ☐ Yes If yes, please list with reaction: ____________________

Major Medical Illnesses

Head Trauma ☐ No ☐ Yes If yes, explain: ____________________

Seizure Disorder ☐ No ☐ Yes If yes, type: ____________________

Asthma ☐ No ☐ Yes ____________________

Heart Problems ☐ No ☐ Yes If yes, explain: ____________________

Diabetes ☐ No ☐ Yes ____________________

High Blood Pressure ☐ No ☐ Yes ____________________

Thyroid Problems ☐ No ☐ Yes If yes, explain: ____________________

Cholesterol Problems ☐ No ☐ Yes If yes, explain: ____________________

Cancers/Radiation/Cherne ☐ No ☐ Yes If yes, explain: ____________________

Repeated ear infections ☐ No ☐ Yes If yes, explain: ____________________

Any birth defects ☐ No ☐ Yes If yes, explain: ____________________

Fainting ☐ No ☐ Yes If yes, explain: ____________________

Chest pain ☐ No ☐ Yes If yes, explain: ____________________

Irregular heart beats ☐ No ☐ Yes If yes, explain: ____________________

Liver disease ☐ No D Yes If yes, explain: ____________________

Kidney disease ☐ No ☐ Yes If yes, explain: ____________________

Other ☐ No ☐ Yes If yes, explain: ____________________

Hospitalizations ☐ No ☐ Yes If yes, explain: ____________________

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Operations ☐ No ☐ Yes If yes, explain: ____________________

Last Physical Exam: ____________________

Blood work in past year ☐ No ☐ Yes If yes, when and results: ____________________

Current Primary Care Physician Name: ____________________ Last Seen: ____________________

Family History ____

(Disorders present in ANY BLOOD RELATIVE of the patient- specify who has the disorder)

Medical Disorders

Heart Problems ☐ No ☐ Yes If yes, explain: ____________________

Sudden Death ☐ No ☐ Yes If yes, explain: (Unknown cause of death prior to 40) ____________________

Seizures ☐ No ☐ Yes If yes, explain: ____________________

Diabetes ☐ No ☐ Yes If yes, explain: ____________________

High Blood Pressure ☐ No ☐ Yes If yes, explain: ____________________

Thyroid ☐ No ☐ Yes If yes, explain: ____________________

Asthma ☐ No ☐ Yes If yes, explain: ____________________

Cholesterol Problems ☐ No ☐ Yes If yes, explain: ____________________

Cancers ☐ No ☐ Yes If yes, explain: ____________________

Glaucoma ☐ No ☐ Yes If yes, explain: ____________________

Others ☐ No ☐ Yes If yes, explain: ____________________

Psychiatric Disorders

Anxiety disorder ☐ No ☐ Yes If yes, explain: ____________________

Bipolar Disorder ☐ No ☐ Yes If yes, explain: ____________________

Depression ☐ No ☐ Yes If yes, explain: ____________________

Anorexia/Bulimia ☐ No ☐ Yes If yes, explain: ____________________

Drug Problems ☐ No ☐ Yes If yes, explain: ____________________

Alcohol Problems D No D Yes If yes, explain: ____________________

Mental Retardation ☐ No ☐ Yes If yes, explain: ____________________

Learning disorder ☐ No ☐ Yes If yes, explain: ____________________

Dyslexia ☐ No ☐ Yes If yes, explain: ____________________

Schizophrenia ☐ No ☐ Yes If yes, explain: ____________________

Completed Suicide ☐ No ☐ Yes If yes, explain: ____________________

ADHD ☐ No ☐ Yes If yes, explain: ____________________

Autism ☐ No ☐ Yes If yes, explain: ____________________

OCD ☐ No ☐ Yes If yes, explain: ____________________

Other ☐ No ☐ Yes If yes, explain: ____________________