UW Medicine
VALLEY MEDICAL CENTER

DIAGNOSTIC EVALUATION

PATIENT SELF REPORT

Name of PCP: __________________________ **Address:** ______________________________________ **Phone:** _____________

Current medications: Please list the names of prescribed and non-prescribed drugs and over the counter herbs/replacements you are using.

Medication (Name, Dose, Frequency)	Clinician Comments

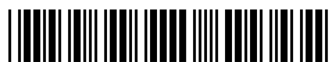
Previous Psychiatric Medications: Please list the names of prescribed and non-prescribed psychiatric drugs you have used in the past.

Name of Medication	Clinician Comments

Do you have any medication allergies? Please list:

____

Previous MEDICAL History	*Clinician Evaluation (for official use only)*
Illnesses: ________________________________ ________________________________ ________________________________ Surgeries: ________________________________ ________________________________ ________________________________ Describe your obstetrical history: ____________________ ________________________________ ________________________________ Describe your method of contraception: ____________________ Have you gained or lost weight in the last 6 months? ☐ Yes ☐ No If yes, explain: ________________________________	____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________



Patient Label

DIAGNOSTIC EVALUATION

Previous PSYCHIATRIC History:	*Clinician Evaluation (for official use only)*
Have you ever been hospitalized? ☐ **Yes** ☐ **No** When? ____ Where? ____ Diagnosis? ____ Benefits? ____ Have you ever seen a Psychiatrist? ☐ Yes ☐ No For what condition? ____ Have you ever seen a Counselor/Therapist? ☐ Yes ☐ No For what condition? ____ Have you ever made suicide attempt? ☐ Yes ☐ No If yes, details: ____ Violence (any self-injury, injury to others)? ☐ Yes ☐ No If yes, explain: ____ Alcohol (quantity per day, is it or has it been a problem)? ☐ Yes ☐ No Drugs (present/past use, is it or has it been a problem)? ☐ Yes ☐ No Caffeine? ☐ Yes ☐ No If yes, describe: ____ Nicotine use? ☐ Yes ☐ No If yes, describe (amount/frequency): ____	

Family/Social History:	*Clinician Evaluation (for official use only)*
Any mental illness in your family (including addictions)? ☐ **Yes** ☐ **No** If yes, describe: ____ Family of Origin (where were you born and raised)? ____ How many siblings? ____ What was childhood like? ____ Marital History? ____	

Patient Label

DIAGNOSTIC EVALUATION

Family/Social History (cont):	*Clinician Evaluation (for official use only)*
Abuse: Sexual abuse? ☐ Yes ☐ No If yes, explain: ______ ______ Physical abuse? ☐ Yes ☐ No If yes, explain: ______ ______ Emotional abuse? ☐ Yes ☐ No If yes, explain: ______ ______ ______ **Current Social/Family System:** Child(ren)? ☐ Yes ☐ No Who are the supports in your life? ______ ______ ______ Who lives with you? ______ ______ Are you working outside the house? ☐ Yes ☐ No If yes, where and doing what? ______ ______ Education? ______ Any legal problems? ☐ Yes ☐ No If yes, explain: ______ ______ ______ Any financial problems? ☐ Yes ☐ No If yes, explain: ______ ______ ______ Any military service? ☐ Yes ☐ No Do you feel safe? (home, work, school)? ______ ______ Sexual Orientation? ______ Religious beliefs/values? ______ ______ What do you do in your spare time? ______ ______ ______ Last physical examination? ______ What are your goals for treatment? ______ ______ ______ ______	______ ______

Patient Label