Ann B. McDowell, M.D.

Dothan Psychiatry and Sleep Disorder Medicine

Patient Information:

Name: _____

Date of Birth: _____ **Age:** _____ **Sex:** _____

What bring you to the office today?

_____

_____

_____

_____

Referred By: _____ **Primary Care Physician**_____

What events took place that may have made you feel like this?

_____

_____

_____

_____

Have you ever had treatment for this problem? (Medications, therapy, tests, etc.)

_____

_____

_____

_____

How would you describe your mood?

Sad: _____ Happy: _____ Anxious: _____ Fearful: _____ Angry: _____

Irritable: _____ Euphoric: _____ Other: _____

How would you describe your sleep? _____

How would you describe your energy? _____

How would you describe your concentration? _____

How would you describe your appetite? _____

Are you easily frustrated? If so, has it become worse? _____

Has your sexual desire changed? Increase or decrease? _____

Are you now or have you ever been suicidal? _____

Do you have obsessive thoughts or behaviors? _____

Do you ever feel worthless, hopeless, helpless, or guilty? _____

Do you ever feel you've lost your ability to feel joy? _____

Do you see visions or hear voices? _____

Do you ever feel that people are watching you, following you, or whispering about you?

_____

Medical Diagnosis and Problems:

_____

_____

_____

_____

- **Do you have any metal implants?** _____
- **Do you have any medical implants?** _____
- **Have you ever had a seizure?** _____
- **Have you ever been diagnosed with obstructive sleep apnea?** _____
- **Are you in a special diet?** _____

Allergies: _____

_____

Past Surgeries: _____

_____

Past Hospitalizations: _____

_____

Medication	Dosage (mg)	How many times a day?	On for how long?	Side effects?	Who prescribes it?

This Section must be completed or list attached**

ALLERGY			ENT		
Runny nose	yes	no	Cold	yes	no
Scratchy throat	yes	no	Nose bleeds	yes	no
Itchy eyes	yes	no	Hearing loss	yes	no
Ear fullness	yes	no	Sore thorat	yes	no
Sinus congestion	yes	no	Ringing in the ears	yes	no
RESPIRATORY			Sinus pain	yes	no
Short of breath	yes	no	**FEMALES**		
Chest congestion	yes	no	Menopause	yes	no
Cough	yes	no	Heavy periods	yes	no
CARDIOLOGY			Painful periods	yes	no
Chest pain	yes	no	Breast pain	yes	no
Palpitations	yes	no	Pelvic pain	yes	no
Swelling of the legs	yes	no	**MALES**		
Varicose veins	yes	no	Difficulty with errections	yes	no
CONSTITUTIONAL			Enlarged prostate	yes	no
Weight gain	yes	no	**GASTRO**		
Loss of appetite	yes	no	Nausea	yes	no
Fever	yes	no	Heartburn	yes	no
Weakness	yes	no	Vomiting	yes	no
Weight loss	yes	no	Abdominal pain	yes	no
Fatigue	yes	no	Difficulty swallowing	yes	no
DERMATOLOGY			Diarrhea	yes	no
Rash	yes	no	Constipation	yes	no
Moles	yes	no	**HEMATOLOGY**		
Lumps	yes	no	Swollen glands	yes	no
Dry or sensitive skin	yes	no	Swollen Lymph nodes	yes	no
Hives	yes	no	Easy bruising	yes	no
Skin cancer	yes	no	**MUSCULOSKELETAL**		
ENDOCRINOLOGY			Joint stiffness	yes	no
Excessive thirst	yes	no	Joint pain	yes	no
Cold intolerance	yes	no	Joint swelling	yes	no
Heat intolerance	yes	no	Leg cramps	yes	no
Diabetes	yes	no	Sciatica	yes	no
Hair loss	yes	no	Fracture	yes	no
Goiter	yes	no	**NEUROLOGY**		
Tired/sluggish	yes	no	Headache	yes	no
UROLOGY			Tingling/numbness	yes	no
Difficulty urinating	yes	no	Seizures	yes	no
Frequent urination	yes	no	Dizziness	yes	no
Urinary incontinence	yes	no	Memory loss	yes	no
Recurrent UTI	yes	no	**OPTHALMOLOGY**		
Frequent urination at night	yes	no	Diminished vision	yes	no
Blood in the urine	yes	no	Cataracts	yes	no
			Eye irritation	yes	no

Check off who in your family has/had the following:

Anxiety: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Depression: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Panic: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Suicidal Behavior: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Psychosis: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Substance Abuse: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Loud Snoring: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Daytime Sleepiness: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

High Blood Pressure: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Stroke: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Heart Disease: Father___ Mother___ Aunt___ Uncle___ Brother___ Sister___ Children ___ Grandparents ___

Have any of your immediate family members (mom, dad, sibling, etc.) ever taken medications for what brings you to us today? If so what medication and did it work well for them?

_____

_____

_____

_____

Where were you born? _____

How many children were in your family? _____ **Where did you rank in the children?** _____

How would you describe your home life as a child?

_____

_____

_____

_____

Education History: (High School, college, graduate school, etc.) Where did you attend, when did you graduate, and what degrees did you obtain?

_____

_____

_____

_____

Job History:

Are you disables? _____ If so for how long? _____

Are you retried? _____ If so for how long? _____

If you are retired, disabled, or unemployed – What was your last job and how long where you there for? _____

_____

Current Occupation: _____

_____

Length of time at this job? _____

Marital Status: (please circle one)

Single Married Separated Widowed Divorced Cohabiting with Partner

Please list any current and previous marriage, when they occurred, how long they lasted, and why it ended? _____

_____

Family Composition: (please lost all people living in your household) _____

_____

What activities do you enjoy doing? _____

_____

_____

_____

_____

Recreational Substances: (please circle if you do any of the following)

Tobacco Alcohol Vaper Cigarette Other: _____

If you smoke – how many cigarettes a day? _____ How long have you smoked? _____

Are you ready or thinking about quitting? _____

If you drink – how often do you drink? _____

What do you drink? _____

How much do you drink? _____

If other please explain? _____

Sleep History:

Do you have any particular problems with your sleep? _____

_____

_____

_____

How long have you had this problem? _____

Have you ever had a sleep study? If so, when and by who? _____

_____

When do you go to bed? Weekdays_____ Weekends _____

How long does it take you to fall asleep? _____

What position do you sleep in? _____ How many pillows do you use? _____

Do you snore? _____ Has anyone ever said you stop breathing in your sleep? _____

How many times do you awake at night? _____ Are you able to easily fall back to sleep? ____

What time do you wake up? _____ Is it on your own or with an alarm? _____

How long from the time you wake up until you get out of bed? _____

How long does it take you to feel alert and awake? _____

Upon waking up do you have any of the following? (please circle)

Headaches Dry Mouth Feeling Groggy Short of Breath Heart Palpitations

Have you had any weight changes in the past year? If so please describe? _____

_____

_____

_____

Do you drink caffeinated beverages? If so how many a day? _____

_____

_____

Do you nap during the day? If so, about how long? _____

Do naps make you feel? (please circle one) Better Worse No Different

What do you do during the day? (if you work please but the hours and number of days a week you work):_____

_____

Do you have concerns about anything else? _____

_____

_____

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE _____

Name: _____

Date: _____

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PHQ-9

NeuroStar®
Advanced Therapy for Mental Health

Patient Health Questionnaire

Patient Name	Date

Over the last two weeks, how often have you been bothered by any of the following problems?
Click the appropriate box to indicate your answer.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could notice. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Healthcare Professional:
For interpretation of total please refer to accompanying score card (reverse side)

add columns 0 + +

total 0

10. If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Would you be interested in learning more about a safe, effective, non-drug treatment for depression?

☐ **Yes** ☐ **No**