Roxann Sangiacomo, M.D., PA
Adult Psychiatry

Name_____ Date_____
Print Legal Name

Address_____
Street Please NO Post Office Boxes

_____
City State Zip Code

What do you preferred to be called (nickname, etc.):_____

Home #_____Work #_____ Cell #_____
Circle YES NO OK To Call Circle YES NO OK To Call Circle YES NO OK To call

DATE OF BIRTH_____ SOCIAL SECURITY #_____

REFERRED BY:_____ PHONE #_____

IF REFERRED BY TREATING PRACTITIONER, DO YOU WANT THEM UPDATED? YES NO

*EMERGENCY CONTACT (MUST FILL IN) _____
NAME PHONE NUMBER

RELATIONSHIP TO YOU_____

EMPLOYER:_____

POSITION:_____ YRS EMPLOYED_____

PRIMARY PSYSICIAN:_____

PHONE #_____ LAST SEEN_____
If known

GYNECOLOGIST:_____
Name Phone Number (if known)

OTHER
SPECIALISTS:_____

This form was filled out by:_____Relationship_____
If other than the Patient

Signature:_____

Name : _____ Date : _____

YOUR MEDICAL HISTORY:

Age: _____

Are you allergic to any medications? Yes___ No___

If yes, please list: _____

_____

_____

_____

Are you currently on medications? Yes ___ No ___

MED DOSE PRESCRIBED BY

_____

_____

_____

_____

_____

Over the counter Meds: MED DOSE Yes ___ No ___

_____

_____

_____

_____

_____

Have you had major surgery? Yes ___ No ___

If yes, list name of operation and year: _____

_____

_____

_____

_____

What Medical Conditions do you have?

CONDITION MANAGED BY WHOM?

_____

_____

_____

_____

_____

Have you ever had a SEIZURE: Yes ____ No____

Have you ever been in a COMA: Yes ____ No ____

Do you have LUNG disease: Yes ____ No ____

Do you have HIGH BLOOD PRESSURE: Yes ____ No ____

Have you had a STROKE: Yes ____ No ____

Do you have DIABETES: Yes ____ No ____

Do you have HEART DISEASE: Yes ____ No ____
(circle: heart attack, leaky valves, irregular heartbeat or other):

Do you have LIVER disease: Yes ____ No ____

Do you have KIDNEY disease: Yes ____ No ____

Have you had BLOOD TRANSFUSIONS: Yes ____ No ____

Do you have STOMACH/BOWEL/COLON problems: (circle) Yes ____ No ____

Do you have severe HEADACHES regularly: Yes ____ No ____

Have you ever had CANCER: Yes ____ No ____

Do you have Arthritis? Yes ____ No ____
What kind? _____

Do you SMOKE? Yes ____ No ____
If yes, how much do you smoke?

A pack or less a day? _____

A pack or more a day? _____

Have you been a VICTIM OF A VIOLENT CRIME? Yes ____ No____

_____

_____

SUBSTANCE USE HISTORY: *Please skip this section if you **DO NOT** use alcohol regularly, (two or fewer drinks 1 week regularly) and do not use other than your own prescription medications according to directions.*

Do you drink alcohol regularly? Yes ____ No ____
Do you use any other drugs? Yes ____ No ____
Have you ever needed help with getting off a drug? Yes ____ No ____
If yes, name: _____
Has overuse of alcohol ever been a problem: Yes ____ No ____

Have you ever been in Rehab or Detox for drug or
Alcohol problems? Yes ____ No ____
Do you go to (please circle) AA, NA, OA Yes ____ No ____

MENTAL HEALTH HISTORY:

Have you seen a Psychiatrist (an M.D. or D.O.) who
specializes in Psychiatry before? Yes ____ No ___

Have you seen a Psychologist (a Ph.D., not a Medical
Doctor) or Therapist before? Yes ____ No ____

Are you in therapy NOW? Yes ____ No ____
With Whom? _____
How Often? _____
How Long? _____
Do they know you are here? Yes ____ No ____

Have you been on medication in the past for:
(please circle) DEPRESSION, ANXIETY, INSOMNIA,
HALLUCINATIONS, NERVES, CONFUSION? Yes ____ No ____
Please list if Recalled: _____
_____
_____
_____
_____

Have you ever been in a Psychiatric Hospital? Yes ____ No ____
When? _____
Where? _____
_____

PERSONAL HISTORY:

Marital Status: Single (never married) _____.

Currently Married ____. Number of times ____. Spouse's Name _____ Age ____

Currently Divorced ____.Number of times ____.

Currently Widowed ___. Number of times ____. Decedents Name _____

Significant other living with you? Yes ____ No ____
First Name: _____

Do you have children? Yes ____ No ____

Names and Age:

lives with you (circle) yes/no: _____

lives with you (circle) yes/no _____

lives with you (circle) yes/no _____

lives with you (circle) yes/no _____

Are any of your children deceased? Yes ____ No ____
Who? _____

Are there other children living with you? Yes ____ No ____

Have you ever given a child up? Yes ____ No ____

Are there other adults living with you? Yes ____ No ____

First Name and Relationship:

Where were you born: _____

Education/Degree: _____

Major: _____ School/Year _____

How long in S.W. FL.? _____

Occupation: _____ Employed now? Yes ____ No ____

Disabled: (how?) _____

Retired: (when?) _____

FAMILY MEDICAL HISTORY:

Mother's age: ____ Deceased: Yes ____ No ____
Medical/Psychiatric History: _____
_____
_____

Father's age: ____ Deceased Yes ____ No ____
Medical/Psychiatric History: _____
_____
_____

# of Brothers ____. # of Sisters ____.

Any deceased? ____ How? _____ Yes ____ No ____
_____
_____

Any Medical or Psychiatric problems that seem to run in your family?
_____? Yes ____ No ____

Relative treated for Depression/Anxiety, etc.: Yes ____ No ____
Who_____?

Family History of Suicide (Immediate or extended family): Yes ____ No ____
Who_____?

Relative Institutionalized in past? (Immediate or extended family): Yes ____ No ____
Who_____?

CURRENT SYMPTOMS (refer to past 2-3 weeks):

Sleep well: Yes ____ No ____

Can't fall asleep: Yes ____ No ____

Fall asleep OK, wake up on and off: Yes ____ No ____

Wake up too early, can't get back to sleep: Yes ____ No ____

Sleep too much: Yes ____ No ____

Good energy: Yes ____ No ____

Always or usually tired: Yes ____ No ____

Frequently irritable: Yes ____ No ____

Frequently tearful: Yes ____ No ____

Feel like running away or disappearing: Yes ____ No ____

Difficulty paying attention/easily distracted: Yes ____ No ____

Trouble concentrating: Yes ____ No ____

Trouble remembering new things or told, “You don’t listen”: Yes ____ No ____

Withdrawing from family or friends: Yes ____ No ____

Stopped hobbies or sports lately: Yes ____ No ____

What?_____

Appetite “normal” for you: Yes ____ No ____

No appetite, “never hungry”: Yes ____ No ____

Always hungry, “can’t stop”: Yes ____ No ____

No interest in food, “eat to exist”: Yes ____ No ____

Do you vomit after eating: Yes ____ No ____

Do you feel “nervous” a lot: Yes ____ No ____

Do you worry “about everything”: Yes ____ No ____

Do you get panic attacks: Yes ____ No ____

Do you have physical symptoms with panic: Yes ____ No ____

Shortness of breath: Yes ____ No ____

Heart races: Yes ____ No ____

Choking sensation: Yes ____ No ____

Feel you’re “going to die” or “pass out”: Yes ____ No ____

Feel a need to “get out of here”: Yes ____ No ____

A “sense of impending doom or dread”: Yes ____ No ____

Do you think about death a lot: Yes ____ No ____
Yours: Yes ____ No ____
Someone else's: Yes ____ No ____

Is your sex drive "normal" for you: Yes ____ No ____
Men: Are you able to perform satisfactorily: Yes ____ No ____
Women: Are you able to achieve orgasm? Yes ____ No ____
If you have a partner, do they complain: Yes ____ No ____

Do you feel you've lost interest in things: Yes ____ No ____
What?_____

Do you have periods (more than 3 days) of Feeling too good: Yes ____ No ____
How long?_____
Making large purchases which later seem irrational: Yes ____ No ____
Doing impulsive things that eventually hurt you: Yes ____ No ____
What?_____

Do you have repeated thoughts that are:
Racing: Yes ____ No ____
Paranoid: Yes ____ No ____
Irrational: Yes ____ No ____
Obsessive: Yes ____ No ____
Intrusive: Yes ____ No ____

Do you frequently feel overwhelmed: Yes ____ No ____

Do you feel your life is "out of control": Yes ____ No ____

Do you exercise regularly: Yes ___ No ____

Additional information: _____

_____

_____

_____

I, _____, attest that the information provided is true

and correct _____.

SIGNATURE