Susan Myers, MD

Patient Intake Form #1

Past Medical History. Please check if you have any of the following problems:

_____Seizures/Convulsions
_____Head Injury
_____Self-Induced Vomiting

_____Glaucoma
_____Heart Disease
_____Irritable Bowel
_____Difficulty Urinating
_____Constipation

_____Stroke
_____Memory Problems
_____Cancer

_____Thyroid Disease
_____Blood Clots
_____Kidney Disease
_____Liver Disease/Hepatitis
_____Low Blood Count

Family History. Please check if any family members such as children, siblings, parents, grandparents, aunts, uncles, or cousins have problems with the following:

_____Depression
_____Mania
_____Anxiety
_____Schizophrenia
_____ADHD
_____Memory Loss/Alzheimer's
_____Cancer
_____Heart Disease

_____Diabetes
_____Trouble w/ anesthesia
_____Tics
_____Neurological problems
_____Alcoholism
_____Drug Abuse
_____Suicide Attempts
_____Psychiatric Hospitalizations

_____Other Psychiatric Problems

Social History. How much/often do you consume the following?

Alcohol_____
Street Drugs_____

Caffeine_____
Tobacco_____

Medications. Please list all medications (including strength and frequency):

Allergies to Medications:

Physicians. List all physicians from whom you receive care: