Dr. Cheryl Hodges, M.D.

Board Certified General Psychiatrist
1981 E. Palmer-Wasilla Highway, #230, Wasilla, AK 99654
907-357-9920 Phone 907-357-9921 Fax

PATIENT HISTORY

NAME: ______________________________ DOB: ______________ DATE: ______________

Primary Care Physician/Address/Phone Number:
____
____

Date of Last Physical Exam: ______________

MEDICAL HISTORY:

Have you had childhood:
☐ Measles ☐ Rheumatic fever or heart disease
☐ Congenital Abnormalities ☐ Mumps ☐ Chicken Pox

Medical illnesses:
☐ Asthma ☐ High Blood Pressure ☐ Cancer
☐ Diabetes ☐ Ulcer or Gastritis ☐ Thyroid Disease
☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problem
☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure
☐ Heart Attack ☐ Osteopenia/Osteoporosis
☐ Arrythmia ☐ Other______________________

SURGERIES:
Have you ever had any surgery? ☐ yes ☐ no
If yes, what type and when:
____
____

ALLERGIES:
____
____

CURRENT MEDICATIONS AND DOSES:
____
____
____
____
____

List **all** past psychiatric medications:
____
____
____

INJURIES/ACCIDENTS:

Have you ever been in a serious motor vehicle accident? ☐ yes ☐ no
Have you had any concussions or head injuries? ☐ yes ☐ no
Have you ever been knocked unconscious? ☐ yes ☐ no

SOCIAL HISTORY:

With whom do you live? ______________________

SUSBSTANCE USE HISTORY:
Do you drink: Coffee ____ Tea ____ Colas ____ (# per day)
Alcohol: ☐ Never ☐ < 1 per week ☐ 1-5 per week ☐ >5 per week
Tobacco: ☐ Never smoked ☐ Quit _____ years ago
☐ Packs per day _____ ☐ Years smoked _____
History of Illicit Drug Usage? ☐ yes ☐ no

Are you employed? ☐ Full Time ☐ Part Time
What is your job?______________________
____

Are you a student? ☐ yes ☐ no If so, where______________
Education: (Years)
School _________ College _________ Post-Grad _________

Spouse's Name/Age:______________________

Children's Names/Ages:______________________
____
____
____

FAMILY HISTORY:

FAMILY MEMBER	AGE	HEALTH	If Deceased, Age @ Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had psychiatric problems, or substance abuse? If so, what illness(s)?
____
____
____

Family history of attempted or completed suicide?
☐ Yes ☐ No Who?______________________
Family history of diabetes, hypertension, or heart disease?
☐ Yes ☐ No Who?______________________

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REVIEW OF SYSTEMS:

Weight:__________ Height:__________

Recent weight change? ☐ yes ☐ no

Have you recently had: ☐ Weakness ☐ Fever ☐ Chills ☐ Fainting

CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Skin
- Skin Disease .... Yes No
- Jaundice .... Yes No
- Hives, eczema, rash .... Yes No

Head-Eyes-Ears-Nose-Throat
- Dry eyes or mouth .... Yes No
- Bleeding gums – frequent or consistent .... Yes No
- Blurred vision .... Yes No
- Date of last eye exam ______________________
- Nosebleeds – frequent .... Yes No
- Chronic sinus trouble .... Yes No
- Ear disease .... Yes No
- Impaired hearing .... Yes No
- Dizziness or sensation of room spinning .... Yes No
- Frequent or severe headaches .... Yes No

Respiratory
- Asthma or Wheezing .... Yes No
- Difficulty breathing .... Yes No
- Pleurisy or Pneumonia .... Yes No
- Cough up Blood (ever) .... Yes No

Cardiovascular
- Chest pain, pressure or tightness .... Yes No
- Shortness of breath with walking or lying down .... Yes No
- Palpitations .... Yes No
- Swelling of hands, feet or ankles .... Yes No
- Awakening in the nights feeling smothered .... Yes No
- Heart murmur .... Yes No

Gastrointestinal
- Vomiting blood or food .... Yes No
- Gallbladder disease .... Yes No
- Change in appetite .... Yes No
- Hepatitis / Jaundice .... Yes No
- Painful bowel movements .... Yes No
- Bleeding with bowel movements .... Yes No
- Black stools .... Yes No
- Recent change in bowel habits .... Yes No
- Frequent diarrhea .... Yes No
- Heartburn or indigestion .... Yes No
- Cramping or pain in the abdomen .... Yes No
- Does food stick in throat .... Yes No

Endocrine
- Hormone therapy .... Yes No
- Any change in hat or glove size .... Yes No
- Any change in hair growth .... Yes No
- Have you become colder than before or skin dryer .... Yes No

Neck
- Stiffness .... Yes No
- Enlarged glands .... Yes No

Genitourinary:
- Loss of urine .... Yes No
- Blood in urine .... Yes No
- Frequent urination .... Yes No
- Burning or painful urination .... Yes No
- Bedwetting .... Yes No
- Kidney trouble .... Yes No
- Testicular mass .... Yes No
- Prostate problem .... Yes No
- Sexual dysfunction .... Yes No
- Sexually transmitted disease .... Yes No

Obstetric-Gynecologic:
- First day of last period ______________________
- Age periods started ______________________
- How long do periods last ______________________
- Frequency of periods every ______________________
- Pain with periods .... Yes No
- Number of pregnancies ______________________
- Number of miscarriages ______________________
- Date of last cancer smear and results ______________________
- Breast lump or discharge .... Yes No
- Abnormal vaginal discharge .... Yes No
- Pain with intercourse .... Yes No

Musculoskeletal
- Stiffness or pain in joints .... Yes No
- Weakness of muscles or joints .... Yes No
- Any difficulty walking .... Yes No
- Any pain in calves/buttocks with walking relieved w/rest .... Yes No
- Autoimmune disease .... Yes No

Neuro-Psychiatric

☐ Transient blindness ☐ Tremor ☐ Weakness ☐ Fingers numb

- Have you ever had counseling for mental health .... Yes No
- Have you ever been advised to see a psychiatrist .... Yes No
- Convulsions or Seizures .... Yes No
- Paralysis .... Yes No
- Problems with coordination .... Yes No
- History of being physically or sexually abused .... Yes No
- Depression symptoms (difficulty sleeping, loss of appetite, loss of interest in activities, feeling hopeless .... Yes No
- History of ADHD .... Yes No
- History of mood swings or bipolar illness .... Yes No
- History of violence or aggression .... Yes No
- History of bingeing or purging .... Yes No

Hematologic
- Are you slow to heal after cuts .... Yes No
- Anemia .... Yes No
- Phlebitis or blood clots in veins .... Yes No
- Have you had difficulty with bleeding excessively after tooth extraction or surgery? .... Yes No
- Have you had abnormal bruising or bleeding .... Yes No

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PSYCHIATRIC OR COUNSELING HISTORY

Have you had previous counseling or psychiatric treatment? Yes No If yes, when? ______________________

If yes, for what reason? ____

Name and location of doctor/therapist: ______________________________________

Length of treatment? ________________ Was it helpful? ______________________

Have you ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, which type? ____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, who and which type? ____

SPIRITUALITY

Do you believe in God? Yes No Not sure What is your religious preference? ________________

How much influence do your spiritual beliefs have on your day-to-day activity?
A lot A moderate amount A little None

REASONS FOR SEEKING HELP

What concerns have brought you to seek treatment? ______________________________

____

____

____

Which of the following are causing the most concern for you? Please check all that apply:

Home Work Marriage Other Relationships God

When did your present concerns begin to be a problem for you? ______________________

What concerns, about you, have been identified by others? ______________________

Please rate the severity of your present concerns on the following scale. Check one:
Mild Moderate Severe Incapacitating

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SYMPTOM CHECKLIST

___ Blackouts or temporary loss of memory
___ Inability to concentrate while at school/work
___ Insomnia (not being able to sleep)
___ Crying spells
___ Loss of appetite/increased appetite
___ Feeling as though you would be better off dead
___ Excessive anxiety or worry
___ Uncontrollable anxiety or worry
___ Lacking self-confidence
___ Loss of interest in usual activities
___ Lack of motivation
___ Feeling fat
___ Obsessions or compulsions with specific activities
___ Eating and then vomiting to control weight
___ Inability to control thoughts
___ Difficulty maintaining friendships
___ Feeling trapped in rooms/buildings
___ Feeling lonely
___ Concerns about emotional stability
___ Hypersomnia (sleeping all the time)
___ Afraid of being on your own
___ Difficulty making decisions
___ Concerns about finances
___ Hearing voices
___ Getting into trouble at school/work
___ Feeling that people are out to get you
___ Feeling inferior to others
___ Under too much pressure and feeling stressed
___ Not being able to say what you really think or feel
___ Feeling down or unhappy/depressed mood
___ Excessive fear of specific places or objects
___ Nightmares
___ Difficulty making friends
___ Inability to control or manage anger
___ Delusions
___ Suspicious feelings toward other people
___ Feeling "on top of the world"
___ Hallucinations
___ Feeling manipulated or controlled by others
___ Angry feelings
___ Abuse of prescription medications
___ Abuse of non-prescription drugs or street drugs
___ Excessive use of alcohol
___ Feeling "numb" or cut off from emotions
___ Concerns about physical health
___ Loss of interest in sexual relationships

Other: ____

____

EMERGENCY CONTACT

Name: ______________________________ Relationship: ______________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Address: ______________________________ City, State, Zip: ______________________

The information provided herein is accurate to the best of my knowledge.

Patient signature: ______________________ Date: __________ Provider: ______________________

Signature of person providing this information: ______________________________________