

# SUNIL K KOTTUR MD

Board Certified - Psychiatry & Child/Adolescent Psychiatry

## Adult Patient

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**Patient Name :** \_\_\_\_\_ **Date:** \_\_\_\_\_

What issues are you seeking help for ? \_\_\_\_\_

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**Current Medications** with dosages ( Also, include over the counter, herbal meds, shots, hormone pills, etc.)

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**Most Recent Psychiatrist:** \_\_\_\_\_

**Any Psychiatric Hospitalizations:** \_\_\_\_\_

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**Name of PCP:** \_\_\_\_\_

**Past Medications tried:**

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**Medical problems** Circle / Checkmark as appropriate:

Heart:  No  Yes If Yes, details \_\_\_\_\_

Seizures:  No  Yes If Yes, details \_\_\_\_\_

Thyroid:  No  Yes If Yes, details \_\_\_\_\_

Liver/Kidney:  No  Yes If Yes, details \_\_\_\_\_

Diabetes:  N  Yes If Yes, details \_\_\_\_\_

High BP:  No  Yes If Yes, details \_\_\_\_\_

Other Medical Problems / Surgeries: \_\_\_\_\_

If applicable: Are you Pregnant? \_\_\_\_\_ Last Menstrual Period \_\_\_\_\_

**Allergies** to Medications, Substances: \_\_\_\_\_

**Family History** Circle / Checkmark as appropriate

Depression:  No  Yes If Yes, who \_\_\_\_\_

Anxiety:  No  Yes If Yes, who \_\_\_\_\_

Bipolar Disorder (Manic Depressive):  No  Yes Who \_\_\_\_\_

Schizophrenia / Psychosis:  No  Yes If Yes, who \_\_\_\_\_

Suicide:  No  Yes If Yes, who \_\_\_\_\_

Psychiatric Hospitalizations:  No  Yes If Yes, who \_\_\_\_\_

Other: (Autism, ADHD, OCD etc.) \_\_\_\_\_

**Trauma** Have you experienced or witnessed any incident which caused distress to you?  No  Yes If yes, details \_\_\_\_\_

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**Social History** Circle / Checkmark as appropriate

Usage of Nicotine?  No  Yes

If Yes,  Current or  Past

Usage of any substances like Marijuana, Alcohol, Street drugs?

No  Yes ; If Yes,  Current or  Past ;

Which one/ones \_\_\_\_\_