SUNIL K KOTTUR MD

Board Certified - Psychiatry & Child/Adolescent Psychiatry

Adult Patient

Patient Name : _____ Date: _____

What issues are you seeking help for ? _____

_____

_____

_____

_____

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

_____

_____

_____

Most Recent Psychiatrist: _____

Any Psychiatric Hospitalizations: _____

_____

Name of PCP: _____

Past Medications tried:

_____

_____

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_____

_____

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_____