FAY M. AZAD, M.D.
Adult & Adolescent Psychiatry
2535 Townsgate Rd., Suite 209
Westlake Village, CA 91361
Telephone (818) 889-8555

Patient Information for medical records

Patient's Name: _____ Date: _____

Date of Birth: _____ Marital Status: Single __ Married __ Divorced __ Widowed__

Legal Guardian (if a minor - under 18 years of age):_____

Street Address: _____ City:_____ Zip:_____

Home Phone: ( ) _____ Work or Cell Phone: ( ) _____

Who do we thank for your referral? _____

In case of an emergency, notify:_____ at ( ) _____

Personal Medical History

Have you ever had any of the following illnesses? Place a check mark if yes,

☐ High blood pressure	☐ diabetes	☐ cancer	☐ stroke
☐ Asthma	☐ birth defect	☐ headaches	☐ epilepsy
☐ Thyroid disease	☐ heart disease	☐ head injury	☐ hepatitis
☐ Peptic ulcer	☐ kidney disease	☐ any other disease	

What is your current weight? _____ Highest weight ever? _____ When? _____

Have you experienced any recent weight loss or gain? ___ Yes __ No

Have you recently had any of the following tests? Place a check mark if yes,

☐ Physical exam ☐ Blood tests ☐ Brain scan, ☐ EEG ☐ ECG

Primary Care Physician's Name: _____ Telephone #: ( )_____

Are you in the habit of using any of the following items?

	Amount currently using	Most ever used
Coffee/Tea/Cola		
Cigarettes (packs per day)		
Alcohol		

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Are you currently taking any medications for your medical condition(s)? ☐Yes ☐ No If yes, please give name(s):_____

Are you currently taking any herbal supplements or over the counter medication(s)? ☐Yes ☐No If yes, please give name(s):_____

Are you currently taking any medication for your psychiatric condition? ☐Yes ☐ No If yes, give names and dosage _____

_____

Have you ever received psychiatric or psychological evaluation or treatment? ☐Yes ☐ No If yes, please provide names of the physicians and dates:_____

Have you ever been hospitalized for psychiatric care? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Are you allergic to any medication? ☐ Yes ☐ No If yes, please give name(s): _____

Do you see a counselor or therapist? ☐ Yes ☐ No

Primary Therapist's Name:_____ Telephone #: ( )_____

Reason for seeking consultation today: _____

_____

Patient's Name: _____Patient's Signature: _____

Legal Guardian if patient is under 18_____Date: _____

For female patient only:

Date of your last menstrual cycle_____ Number of pregnancies_____

Do you experience any change in your mood associated with your menstrual cycle? ☐ Yes ☐ No If yes, please explain_____

Do you use contraceptive methods? ☐ Yes ☐ No If yes, which one? _____

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Name _____Date of Appointment _____

Below is a list of problems or concerns that people sometimes have. Please read the phrases carefully and place a check mark to the left of each phrase if you have been experiencing or have been bothered by the mentioned feeling.

Past	**Current**	
_____	_____	Feeling anxious, nervous, or fearful for no apparent reason
_____	_____	Apprehension or a sense of impending doom
_____	_____	Feeling stressed, tense, uptight, or on edge
_____	_____	Frightening fantasies or daydreaming
_____	_____	Feeling on the verge of losing control
_____	_____	Fear of physical illness or dying
_____	_____	Feeling pain, pressure, or tightness in the chest
_____	_____	Feeling a choking or smothering sensation or difficulty breathing
_____	_____	Trembling or shaking
_____	_____	Feeling dizzy, lightheaded, or off-balance
_____	_____	A lump in the throat, rubbery or jelly legs
_____	_____	Having to repeat the same action in a ritual (checking, washing, counting, etc.)
_____	_____	Recurring words or thoughts that are mentally intrusive and difficult to get rid of
_____	_____	Anxiety episodes that built up in anticipation of doing something
_____	_____	Feeling sad with little or no provocation

Name _____

Past	Current	
_____	_____	Emotions and moods fluctuating dramatically in response to environmental changes
_____	_____	Feeling edgy, easily frustrated, or irritable
_____	_____	Feeling tired, weak, or exhausted easily
_____	_____	Losing interest in most of the things that were previously enjoyable
_____	_____	Experiencing weight loss or gain for no apparent reason
_____	_____	Using alcohol or drugs to get going or to relax
_____	_____	Having trouble sleeping or staying asleep
_____	_____	Feelings of worthlessness, guilt, or self-blame
_____	_____	Difficulty with concentration or decision making
_____	_____	Difficulty with daily activities at work, school, or home
_____	_____	Having thoughts of self-harm or ending life

*Has there been a **period of time** when you were not your usual self and…*

_____ Felt so good or hyper that you got in trouble?

_____ Slept very little and didn't miss it?

_____ Felt much more self-confidence than before?

_____ Were much more talkative or spoke much faster than usual?

_____ Had much more energy than usual?

_____ Were much more interested in sex than usual?

_____ Spent so much money that it got you into trouble?

_____ Did things that were excessive, foolish, or risky?

_____ Had racing thoughts and couldn't slow your mind down?