N A N C Y C. W H E E L E R , M . D . , P . A.
PATIENT INFORMATION

Instructions: Please fill out this form as completely as you can.

Today's Date: _____
Last, First Name: _____
Date of Birth: _____
Marital Status: _____
Gender: _____
Occupation: _____
Year in School: _____
Home Address: _____
Home Phone: _____
May We Leave a Message? Y / N
Cell Phone: _____
May We Leave a Message? Y / N
Other Phone: _____
May We Leave a Message? Y / N

Emergency Contact

Name: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Referral Source

Name: _____
Relationship to You: _____

Pharmacy

Please provide the name and phone number of the pharmacy you usually use.

Name: _____
Phone Number: _____

Provider Information:

Please provide the names and phone numbers of any providers you see regularly. Please include physicians, therapists, and complementary health practioners.

Name: _____
Phone Number: _____
Type of Provider: _____

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Phone Number: _____
Type of Provider: _____

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Type of Provider: _____

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Type of Provider: _____

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Phone Number: _____
Type of Provider: _____

Medical History

Medical Issues: Please list all major medical problems, present and past

_____
_____
_____
_____
_____
_____
_____

Surgeries: Please list any operations you have had, and approximately when and why.

_____
_____
_____
_____
_____
_____

Allergies: Please list any medication or foods to which you have had a bad reaction.

Medication or Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications and Supplements:
Please list all medications and supplements that you take. Includes any over-the-counter drugs that you take more than once a week.

Medication	Dose	How often?	Reason you Take It

Substances: Please mark whether you are currently using any of the following substances now or in the past. Only mark the substance if it was used or is being used without a prescription.

Substance	Now	Past	Concerned About Your Use?
Alcohol	____	____	____
Amphetamines/Stimulants	____	____	____
Cocaine	____	____	____
Hallucinogens	____	____	____
Illicit Prescription Drugs	____	____	____
Ketamine	____	____	____
Marijuana	____	____	____
Opioids (Heroin, pain medication)	____	____	____
PCP	____	____	____
Sedatives/Benzodiazepines	____	____	____
Tobacco Products	____	____	____
Other:_____	____	____	____
Other:_____	____	____	____

Psychiatric History:

Hospitalizations: Please list any psychiatric hospitalizations you have had.

Hospital	When	Reason

Past Medications:
The medications below are sometimes prescribed for psychiatric problems. Please check any that you have taken in the past:

- o Abilify
- o Adderall
- o Alprazolam
- o Ambien
- o Amitriptyline
- o Amoxapine
- o Amphetamine
- o Anafranil
- o Aripiprazole
- o Ativan
- o Atomoxetine
- o Buproprion
- o BuSpar
- o Buspirone
- o Carbamazepine
- o Celexa
- o Chlordiazepoxide
- o Chlorpromazine
- o Citalopram
- o Clomipramine
- o Clonazepam
- o Clozapine
- o Clozaril
- o Concerta
- o Cylert
- o Cymbalta
- o Dalmane
- o Depakene
- o Depakote
- o Desipramine
- o Desvenlafaxine
- o Dexedrine
- o Dextroamphetamine
- o Diazepam
- o Divalproex sodium
- o Doxepin
- o Duloxetine
- o Effexor
- o Elavil
- o Escitalopram
- o Eskalith
- o Fanapt
- o Fluoxetine
- o Fluvoxamine
- o Focalin
- o Gabapentin
- o Geodon
- o Haldol
- o Haloperidol
- o Imipramine
- o Inderal
- o Klonopin
- o Lamictal
- o Lamotrigine
- o Librium
- o Lexapro
- o Lithium
- o Lithobid
- o Lorazepam
- o Luvox
- o Metadate
- o Methylin
- o Methylphenidate
- o Mirtazapine
- o Modafanil
- o Nardil
- o Navane
- o Nefazodone
- o Neurontin
- o Nortriptyline
- o Olanzapine
- o Oleptro
- o Paliperidone
- o Pamelor
- o Parnate
- o Paroxetine
- o Paxil
- o Perphenazine
- o Phenelzine
- o Pristiq
- o Prolixin
- o Propranolol
- o Provigil
- o Prozac
- o Quetiapine
- o Remeron
- o Restoril
- o Risperdal
- o Risperidone
- o Ritalin
- o Saphris
- o Seroquel
- o Sertraline
- o Serzone
- o Sinequan
- o Strattera
- o Tegretol
- o Temazepam
- o Thorazine
- o Tofranil
- o Topomax
- o Topiramate
- o Tranylcypromine
- o Trazodone
- o Valium
- o Valproic acid
- o Venlafaxine
- o Viibryd
- o Vyvanse
- o Wellbutrin
- o Xanax
- o Ziprasidone
- o Zoloft
- o Zyprexa

Past Therapists: Please list all mental health professionals whom you have seen.

Name	When	Reason

Family Psychiatric History: Please list any blood relatives who have been diagnosed with a mental illness.

Relationship	Illness