

Doctor: Dmitry Byk, M.D. Psychiatric Record

Patient ID: _____ Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ FL: _____ ZIP: _____

Primary Phone: (____) _____ Secondary Phone: (____) _____ SSN: _____

Gender: _____ Marital Status: _____ Email: _____

Referred By: _____ Preferred Contact Number: Primary Phone Secondary Phone

Employer Name: _____ Address: _____

In your own words, briefly state what brings you to the office to see the doctor?

Previous Psychiatric History

Have you ever been...	to a psychiatrist(M.D./D.O.)?	to a psychologist/therapist(PhD/PsyD/LCSW/LMHC)?	Been in a psychiatric hospital
Who?			
When?			
Where?			
Reason?			

Have you ever been on psychiatric medications other than what you're on now(i.e. antidepressants, antianxiety, antipsychotics, etc...)?

Name of medicine	Dose	Times per day	How long were you on it?	Why did you stop?

Substance Use History

Do you now or have you in the past ever drank alcohol or smoked cigarettes?

Age at first use: _____ Last time used: _____ How much used: _____ How often: _____

Age at first use: _____ Last time used: _____ How much used: _____ How often: _____

Do you now or have you in the past ever used an illegal drug or used a prescribed medication more often than it was prescribed?

Substance Used: _____

Age at first use: _____ Last time used: _____ How much used: _____ How often: _____

Substance Used: _____

Age at first use: _____ Last time used: _____ How much used: _____ How often: _____

Substance Used: _____

Age at first use: _____ Last time used: _____ How much used: _____ How often: _____

Substance Used: _____

Age at first use: _____ Last time used: _____ How much used: _____ How often: _____

Family Psychiatric History

Has any blood relative in your family been seen by a psychiatrist or psychologist? Yes ___ No ___

Has any blood relative in your family been in a psychiatric hospital? Yes ___ No ___

Has any blood relative in your family attempted or completed suicide? Attempted ___ Completed ___

Has any blood relative in your family had in the past or currently have any of the following diagnoses?

___ Major depression ___ PTSD ___ Generalized Anxiety Disorder ___ Schizophrenia ___ Alzheimer's Disease ___ Borderline Personality Disorder

___ Other psychiatric issues

Medical History

Do you have any of the following medical problems? Current Primary Care Physician: _____

atrial fibrillation anemia arthritis coronary artery dz high cholesterol CHF COPD diabetes I or II

acid reflux disease high blood pressure hypothyroidism previous heart attacks osteoarthritis or osteoporosis parkinson's dz

epilepsy/seizures cancer: type _____ TIA or Stroke

Any other medical problems not listed? _____

What medications are you currently taking(list all including psychiatric and medical)? None

Name of medication	Dose	How many times per day	How long have you been on it	Doctor that started the medication

Please Sign: _____ Reviewed By: _____