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? |
|---|---|---|---|---|
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## Substance Use History

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

Alcohol Age 1st used _____ Last time used: _____ How much used: _____ How often: _____

Cigs Age 1st used 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? Attemped ___ 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 ☐ hypothroidism ☐ previous heart attacks ☐ osteoarthritis or osteoperosis ☐ parkinson's dz

☐ epilepsy/seizures ☐ cancer: type _____ ☐ TIA or Stroke

Any other medical problems not listed? _____ Allergies to Medications:

What medications are you currently taking(list all including psychiatric and medical)? Or provide a list separately

| Name of medication | Dose | How many times per day | How long have you been on it | Doctor that started the medication |
|---|---|---|---|---|
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Please Sign: