MARIETTA PSYCHIATRY ASSOCIATES PC
670 North Ave NW, Suite 200,
Marietta, GA 30060-1100
Phone: 770-678-7034 Fax: 770-678-7035

Medical History

Check all that the patient has experienced and year and month of onset

	Mo/Yr
__ Allergies	
__ Food allergies	____/____
__ Animal allergies	____/____
__Seasonal allergies	____/____
__Medication allergy	____/____
__Insect allergies	____/____
__Other allergies	____/____
__ Anemia	____/____
__ Asthma	____/____
__ Autoimmune diseases	____/____
__Birth difficulties	____/____
__Blood disorders	____/____
__Bone disease	____/____
__Cancer	____/____
__Celiac disease	____/____
__Cerebral Palsy	____/____
__Constipation	____/____
__Cystic fibrosis	____/____
__Eczema	____/____
__Endocrine or hormonal problems	____/____
__Eosinophilic Esophagitis	____/____
__Food Intolerance	____/____
__Gastroesophageal Reflux	____/____
__Genetic disorders	____/____
__Growth issues	____/____
__Heart disease	____/____
__ Hearing problems, or wears hearing aids	____/____
__ Hernia	____/____

__ Immune deficiency _____/_____
__Joint pain _____/_____
__Kidney disease _____/_____
__Migraine headaches _____/_____
__Prematurity _____/_____
__Scoliosis _____/_____
__Seizure _____/_____
__Sleep disturbances _____/_____
__Stroke _____/_____
__Thyroid problems _____/_____
__Vision problems, or wears eye glasses _____/_____
__Chronic vomiting _____/_____
__Weight issues _____/_____

Developmental and Psychiatric History ***Mo/Yr***
__ADHD _____/_____
__Anxiety _____/_____
__Autism _____/_____
__Aggression/Irritability _____/_____
__Conduct disorder _____/_____
__Depression _____/_____
__Developmental Delays _____/_____
__Eating disorder _____/_____
__Feeding difficulties _____/_____
__Learning disorders _____/_____
__Oppositional Defiant Disorder _____/_____
__Self harm or cutting _____/_____
__Substance abuse _____/_____
__Suicide attempt or ideation _____/_____
__Tourette's Syndrome _____/_____
__Other _____ _____/_____

Services and Therapy Interventions Received
__Individualized Education Plan (IEP) in school. _____/_____
__504 Plan in school _____/_____
__Early Intervention Services in early childhood. _____/_____
__Individualized Family Service Plan (IFSP) _____/_____
__Speech therapy _____/_____
__Occupational therapy _____/_____
__Physical therapy _____/_____
__Psychotherapy _____/_____

__Applied Behavioral Analysis (ABA) ____/____
__Respite Care ____/____

Surgeries

__Circumcision (if applicable) ____/____
__Adenoidectomy ____/____
__Tonsillectomy ____/____
__Appendectomy ____/____
__Ear surgery ____/____
__Bowel resection ____/____
__Heart surgery ____/____
__Hernia repair ____/____
__Surgery for fractures ____/____
__Other surgery, please specify _____ ____/____

Please list hospitalizations with reason for hospitalization, and admission and discharge dates:

Reason for hospitalization	Admission date	Discharge date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Ethnicity: __Hispanic or Latino __ Non-Hispanic or non-Latino
Parents' Relationship: __Married __Divorced __Widowed __Single __Separated
Patient resides with:
Primary __Mother __ Father __ Both Parents __ Other
Secondary __ Mother __ Father __ Both Parents __ Other __ Not Applicable
Number of brothers who live in the home: _____
Number of sisters who live in the home: _____
Number of siblings who no longer live at home: _____

Childcare: __ Mother __ Father __ Grandparent/s __ Nanny __ Daycare __ Other

Tobacco Exposure __ Yes __ No Smokers at Home __ Yes __ No

Pets __ Yes __ No; If yes, please specify: _____

International travel to: 1)_____ Dates: From_____to_____
2)_____ Dates: From_____to_____
3)_____ Dates: From_____to_____

Medication History

Name	Strength	Form	# of times/day
For example			
Amoxicillin	250 mg	chewable	three times a day
1)_____	_____	_____	_____
2)_____	_____	_____	_____
3)_____	_____	_____	_____
4)_____	_____	_____	_____
5)_____	_____	_____	_____
6)_____	_____	_____	_____
7)_____	_____	_____	_____
8)_____	_____	_____	_____
9)_____	_____	_____	_____
10)_____	_____	_____	_____

Medication Allergy

Medication	Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____

Family history

	Mother	Father	Brother	Sister	Grandmother	Grandfather
Allergies	_____	_____	_____	_____	_____	_____
Autoimmune disease	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Blood disorder	_____	_____	_____	_____	_____	_____
Clotting disorder	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Celiac disease	_____	_____	_____	_____	_____	_____
Constipation	_____	_____	_____	_____	_____	_____
Cystic fibrosis	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Eczema/ skin problems	_____	_____	_____	_____	_____	_____
Food intolerance	_____	_____	_____	_____	_____	_____
Gastroesophageal reflux	_____	_____	_____	_____	_____	_____
Genetic disorders	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____
Hearing impairment	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____
Immune deficiency	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____
Migraine headache	_____	_____	_____	_____	_____	_____

Seizure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Sleep disturbances	_____	_____	_____	_____	_____	_____
Thyroid problems	_____	_____	_____	_____	_____	_____
Vision problems	_____	_____	_____	_____	_____	_____
Mental illnesses as follows:						
Suspected or known ADHD	_____	_____	_____	_____	_____	_____
Suspected or known autism	_____	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____	_____
Bipolar disorder	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____
Suicidal attempt	_____	_____	_____	_____	_____	_____
Eating disorder	_____	_____	_____	_____	_____	_____
Substance abuse	_____	_____	_____	_____	_____	_____

Anything else we should be aware of regarding the patient: _____
_____