CARLY SNYDER, M.D.

Comprehensive
Reproductive Mental
Healthcare

NAME: DOB:
DATE:

LIST OF CURRENT SYMPTOMS + REFERRING PROVIDER

_____
_____
_____

PAST PSYCHIATRIC HISTORY:
DIAGNOSIS(ES) / PROVIDERS (DATES) / ARE YOU CURRENTLY IN TREATMENT / ARE YOU IN THERAPY
MAY I CONTACT YOUR PROVIDERS? PLEASE PROVIDE THEIR CONTACT INFORMATION IF POSSIBLE.
FEEL FREE TO USE THE BACK IF NECESSARY

_____
_____
_____

PAST MEDICATION TRIALS:
DATES, AGE, DOSES, ADVERSE REACTION(S)

_____
_____
_____

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS
DOSES, PRESCRIBED BY, DATES OF USE

_____
_____
_____

HAVE YOU EVER BEEN PSYCHIATRICALLY HOSPITALIZED:
WHY, DATES, HOSPITAL NAME

_____

MEDICAL PROBLEMS:
PROVIDER(S), DATE OF DIAGNOSIS, TREATMENT IN PAST/NOW

_____
_____

DO YOU HAVE ANY DRUG OR FOOD ALLERGIES: *(PLEASE USE THE BACK IF NEEDED)*
TO WHAT MEDICATION(S) / REACTION(S)

NAME: DOB:

FAMILY HEALTH ASSOCIATES
201 East 87th Street, #16J
New York, NY 10128
212-348-0175
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DATE:

ARE YOU PREGNANT? ARE YOU HOPING/PLANNING TO CONCEIVE IN THE NEXT 6 MONTHS?

_____

NUMBER OF LIFETIME PREGNANCIES / NUMBER OF CHILDREN, DATE(S) OF BIRTH(S)?
MODE OF DELIVERY (C/S OR VAGINAL DELIVERY), WAS YOUR DELIVERY TRAUMATIC IN ANY WAY AND/OR AN EMERGENCY?
(YOU ARE WELCOME TO EXPLAIN MORE ON THE BACK)

_____

DOES ANYONE IN YOUR FAMILY HAVE PSYCHIATRIC ILLNESS?
WHO/DIAGNOSIS/TREATED WITH? DID YOUR MOTHER/GRANDMOTHER SUFFER FROM ANY MOOD SYMPTOMS DURING OR AFTER PREGNANCY THAT YOU KNOW OF?

_____
_____
_____

DRUG(S)/ALCOHOL/TOBACCO USE?
AMOUNT DAILY/WEEKLY / CURRENT OF PAST USE
WHEN DID YOU QUIT? HOW LONG DID YOU USE/ AGE AT HEAVIEST USE?

_____

ANYTHING ELSE YOU WANT ME TO KNOW PRIOR TO YOUR VISIT?

_____
_____
_____

HEIGHT: _____ WEIGHT: _____

IS THIS YOUR NORMAL WEIGHT?_____

IF NOT, WHAT IS YOUR AVERAGE WEIGHT?_____

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