RENÉE BIBEAULT, M.D.

PSYCHIATRY FOR WOMEN

HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions as fully and candidly as possible. Many topics are sensitive, and all responses are optional. Your answers are held in strictest confidence as a part of your medical record.

Name _____ DOB _____

Address (no P.O. boxes): _____

City _____ State _____ Zip _____

Email _____

Mobile Phone _____ Emergency Contact Phone _____

Emergency Contact Name _____

How did you hear of Dr. Bibeault? _____

Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Names and ages of your children, if any _____

Please describe your main reason for visiting the doctor today:

_____

_____

_____

Describe any additional concerns you hope to get help with:

_____

_____

_____

PERSONAL HEALTH HISTORY

I consider my overall health to be ☐ Excellent ☐ Good ☐ So-so ☐ Poor

Please list any medical problems that other doctors have diagnosed:

_____

_____

_____

List your prescribed drugs and any over-the-counter drugs and supplements:

Drug name	Dose	Frequency

Please list your surgeries:

Year	Type of surgery and reason	Results

List any hospitalizations (exclude normal childbirth, mental health or surgery):

Year	Reason for hospitalization	Results or outcome

List any allergic or other adverse reactions to medicines:

Name of drug	Reaction you had

HEALTH HABITS

Number of caffeinated drinks per day _____

Any tobacco? ☐ Never smoked ☐ Smoked but quit ☐ Smoker: _____ cigarette per day

Number of alcoholic drinks per week _____ ☐ I abstain from alcohol

If you abstain, is it because drinking has led to problems for you? _____

Many people with emotional struggles use recreational drugs to cope with their symptoms. Please describe your use of drugs like pot, cocaine, narcotics, speed.

Drug	What you like(d) about this drug	Still using?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever received treatment for drug use problems? ☐ No ☐ Yes If yes, please describe:

_____

_____

SEXUAL HISTORY

I consider myself: ☐ Heterosexual ☐ Bisexual ☐ Lesbian ☐ Nonsexual ☐ Unsure

Estimate your lifetime number of sexual partners _____

Describe any concerns you have about your sexuality (e.g., inability to orgasm, low drive, sex not fulfilling, confused about it in general):

_____

_____

_____

REPRODUCTIVE HISTORY

Are you currently pregnant? ☐ Yes, _____ weeks ☐ No ☐ Trying to conceive

Are you breastfeeding? ☐ No ☐ Yes, as sole nutrition ☐ Yes, part-time ☐ Weaning

Date of last menstrual period _____ ☐ I no longer have periods

Are your periods regular? ☐ Always ☐ Mostly yes ☐ Mostly no ☐ Not at all ☐ N/A

Number of pregnancies _____ Number of live births _____

Describe any emotional problems you've experienced while on the pill or implanted contraception, when using progesterone or estrogen, or have pre- menstrually (PMS):

_____

_____

_____

Please identify your current method of contraception:

☐ Vasectomy ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Abstinence ☐ Menopause ☐ Other

MENTAL HEALTH HISTORY

My childhood was: ☐ Happy ☐ Unhappy ☐ Somewhere in between ☐ Traumatic

Please describe any stressful early life events (e.g., parental conflict, death of a loved one, multiple moves/schools, difficulty with friends, aloneness, learning problems, emotional neglect or abuse, physical or sexual abuse):

_____

_____

_____

_____

Please describe any previous experience with counselors or therapists:

Who you saw	For what issue	length of time

List any medicines you've tried for psychiatric reasons:

Name of Medicine	Used for what symptoms	Results

What name or diagnosis, if any, have doctors given to your emotional struggles?

_____

_____

_____

Have you ever attempted suicide? _____

Have you ever needed hospitalization for emotional or psychiatric reasons? _____

FAMILY AND GENETIC HISTORY

Please indicate symptoms or illnesses suffered by any blood relatives:

Symptom or disorder	Who has/had it	Treated for it?
Depression	_____	_____
Anxiety	_____	_____
Obsessions or compulsions	_____	_____
Alcohol or drug problem	_____	_____
Suicide or suicide attempt	_____	_____
Schizophrenia or other psychosis	_____	_____
Postpartum depression	_____	_____
Sensitivity to hormone changes	_____	_____
Other (please describe):		
_____	_____	_____
_____	_____	_____

SOCIAL AND VOCATIONAL HISTORY

Educational background:

☐ High school ☐ GED ☐ Some college ☐ 2 yr degree ☐ 4 yr degree or more

If employed outside the home, help me understand your job (title, your main functions and responsibilities):

_____

_____

My job stress is: ☐ Nonexistent ☐ Manageable ☐ Too high ☐ Overwhelming

If partnered, how happy are you in the relationship?

☐ Very happy ☐ Somewhat happy ☐ Somewhat unhappy ☐ Not happy at all

I have enough friends and other support in my life: ☐ True ☐ Not true ☐ Unsure

Thank you for completing this.

SUBMIT