

Psychiatry Evaluation Prototype

Patient Name

Patient DOB

MRN

Date	Chief complaint/Reason for consult	Referring MD
Start time Stop time		
Substance Use History	History of Present Illness <input type="checkbox"/> Patient is Nonverbal. History obtained from <input type="checkbox"/> Family <input type="checkbox"/> Medical records	
<input type="checkbox"/> Never Smoker <input type="checkbox"/> Tobacco ____ # Packs X ____ # Yrs <input type="checkbox"/> Quit <input type="checkbox"/> Patient is unwilling to quit <input type="checkbox"/> Patient willing to consider quitting <input type="checkbox"/> Patient quit, but resumed smoking <input type="checkbox"/> Patient willing to quit within 1 month Patient has tried <input type="checkbox"/> Nicotine replacement <input type="checkbox"/> Bupropion or nortriptyline <input type="checkbox"/> Nicotine receptor blockade <i>Daily, occasional and ex-smokers are more likely to be hazardous drinkers</i> <input type="checkbox"/> Alcohol use Drinks per <input type="checkbox"/> day <input type="checkbox"/> week Hazardous drinking <i>NIAAA (National Institute on Alcoholism and Alcohol Abuse guidelines)</i> Men > 14 drinks per week OR > 4 drinks per day Women > 7 drinks per week OR > 3 drinks per day <input type="checkbox"/> Recreational drug use <input type="checkbox"/> Inhalational <input type="checkbox"/> Injectable <input type="checkbox"/> Ingestible <input type="checkbox"/> Drug dependence <input type="checkbox"/> Narcotics <input type="checkbox"/> Benzodiazepines	www.e-medtools.com www.e-medtools.com <input type="checkbox"/> Depressed mood most of the day <input type="checkbox"/> Diminished interest in friends, family, usual activities <input type="checkbox"/> Significant weight loss or gain <input type="checkbox"/> Insomnia or hypersomnia <input type="checkbox"/> Psychomotor retardation or agitation <input type="checkbox"/> Fatigue <input type="checkbox"/> Feelings of worthlessness or excessive guilt <input type="checkbox"/> Decreased concentration <input type="checkbox"/> Loss of ability to carry out daily functions <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> No plan <input type="checkbox"/> With plan <input type="checkbox"/> Homicidal ideation <input type="checkbox"/> No plan <input type="checkbox"/> With plan Past Psychiatric History <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Depression <input type="checkbox"/> Mania <input type="checkbox"/> Psychosis <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Hospitalizations for psychiatric illnesses <input type="checkbox"/> History of ECT <i>Last treatment</i> <i>Last hospitalization</i> <input type="checkbox"/> Prior Suicide attempts <i>Last attempt</i> <input type="checkbox"/> Inflated self esteem, or grandiosity <input type="checkbox"/> Pressured speech <input type="checkbox"/> Flight of ideas <input type="checkbox"/> More easily distractible <input type="checkbox"/> Increase in goal-directed activity <input type="checkbox"/> Excessive involvement in pleasurable activities <input type="checkbox"/> Increased restlessness, or feeling keyed up <input type="checkbox"/> Hallucinations <input type="checkbox"/> New or increased substance abuse <input type="checkbox"/> Patient has the means to carry out Suicidal Plan <input type="checkbox"/> Patient has the means to carry out Homicidal Plan	
Allergies	Review of Systems	
<input type="checkbox"/> Allergy List reviewed <input type="checkbox"/> No drug allergies <input type="checkbox"/> No food allergies Medications <input type="checkbox"/> Medications reviewed <input type="checkbox"/> Medications reconciled with Nursing Home or Hospital discharge Information ★46 Changes as follows	<input type="checkbox"/> Constitutional <input type="checkbox"/> Fatigue <input type="checkbox"/> malaise <input type="checkbox"/> fever/chills <input type="checkbox"/> change in appetite <input type="checkbox"/> Eyes <input type="checkbox"/> Vision changes <input type="checkbox"/> New pain <input type="checkbox"/> Scotomas <input type="checkbox"/> ENT/mouth <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Dental caries <input type="checkbox"/> dental abscesses <input type="checkbox"/> jaw pain <input type="checkbox"/> Resp <input type="checkbox"/> Dyspnea <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Wheeze <input type="checkbox"/> CV <input type="checkbox"/> Chest pain <input type="checkbox"/> diaphoresis <input type="checkbox"/> Ankle edema <input type="checkbox"/> PND <input type="checkbox"/> syncope <input type="checkbox"/> GI <input type="checkbox"/> Nausea <input type="checkbox"/> Weight changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal pain <input type="checkbox"/> GU <input type="checkbox"/> Change in urinary habits <input type="checkbox"/> Hematuria <input type="checkbox"/> Dysuria <input type="checkbox"/> Musc <input type="checkbox"/> Myalgias <input type="checkbox"/> Recent trauma <input type="checkbox"/> Bony fractures <input type="checkbox"/> Arthralgias <input type="checkbox"/> Joint swelling <input type="checkbox"/> Skin/breasts <input type="checkbox"/> Rashes <input type="checkbox"/> Masses or skin lesions <input type="checkbox"/> Increased sensitivity to sun <input type="checkbox"/> Neuro <input type="checkbox"/> Seizures <input type="checkbox"/> Episodic or chronic muscle weakness <input type="checkbox"/> Headaches <input type="checkbox"/> Endo <input type="checkbox"/> Hair loss <input type="checkbox"/> Polydipsia <input type="checkbox"/> Heme/lymph <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Unusual bruising <input type="checkbox"/> swollen lymph nodes <input type="checkbox"/> Allergy/Immun <input type="checkbox"/> Sinus probs <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Psych See HPI	
Family Medical History	Past Medical	Surgical History
<input type="checkbox"/> Asthma <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> CHF <input type="checkbox"/> Substance abuse <input type="checkbox"/> COPD <input type="checkbox"/> Thrombotic Disorder <input type="checkbox"/> CAD <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Malignancy <input type="checkbox"/> Thalassemia <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Major Depressive Disorder <input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Asthma <input type="checkbox"/> Malignancy <input type="checkbox"/> Cerebral Artery Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Neuromuscular weakness <input type="checkbox"/> COPD <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Renal Dysfunction <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Hepatic Dysfunction <input type="checkbox"/> Thrombotic Disease <input type="checkbox"/> HIV or AIDS <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Tuberculosis	

