***Poehailos, Dupont, & Associates, PLC***

**Intake Questionnaire for Pharmacogenomic Testing Consultation**

**Name:**

**Sex:**

**Date of Birth:**

**Employer:**

**Occupation:**

**Highest Level of Education Attained:**

**Current Primary Care Provider (name and contact information)**:

**Referral Source:**

**List of Current/Past Psychiatric Medications (names only):**

**Reason(s) for your interest in genetic testing:**

If the office has indicated you are a good candidate for genetic testing, please answer the following questions to the best of your knowledge and send the completed document for review at least 2 business days in advance of your appointment.

**Psychiatric History: Medication Management and/or Psychotherapy** – Name of provider, dates of service, and treatment focus.

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**Medical History –** history of chronic medical conditions, surgery, serious injury (broken bones, head injury), seizures, or other relevant medical information

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**Current Psychiatric Medications –** Name, Dose, Time of day/ Reason(s) for taking/Start date/Prescriber/Benefit(s)/Side effect(s)

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**Past Psychiatric Medications –** Name, Dose, Time of day/ Reason(s) for taking/Start date/Prescriber/Benefit(s)/Side effect(s)

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**Current Non-Psychiatric Medications –** Name, Dose, Time of day/ Reason(s) for taking/Start date/Prescriber/Benefit(s)/Side effect(s)

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**Medication Allergies** (please describe reaction):

**Other Allergies** (e.g. food, environment)**:**

**Family Medical History -** Please note any family members (siblings, parents; maternal/paternal grand-parents, aunts, uncles, cousins) with history of the following. Indicate ‘none’ or ‘unknown’ when appropriate.

High or low blood pressure:

Heart attack or stroke:

Heart defect at birth:

High cholesterol:

Diabetes (type 1 or type 2):

Obesity:

Thyroid Hormone Imbalance (high or low):

Seizure Disorder:

Parkinson’s/Alzheimer’s/Other neurological disorder(s):

**Family Psychiatric History -** Please note any family members (siblings, parents; maternal/paternal grand-parents, aunts, uncles, cousins) with history of the following. Please also indicate, if known, any treatment or medication received. Indicate ‘none’ or ‘unknown’ when appropriate.

Depression:

Anxiety/Phobia/Panic Attacks:

ADHD (Attention Deficit Hyperactivity Disorder):

Autism Spectrum Disorder:

Other Developmental Disorder:

OCD (Obsessive Compulsive Disorder):

PTSD (Post Traumatic Stress Disorder):

Bipolar Disorder:

Schizophrenia:

Substance Abuse:

Any family members with history of hospitalization for psychiatric reasons: