

Personal Information

Instructions Please fill out this form as completely as you can. *Print your answers.*

Today's Date	<input type="text"/>	Marital Status	<input type="text"/>
First Name	<input type="text"/>	Ethnicity	<input type="text"/>
Last Name	<input type="text"/>	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	<input type="text"/>	Occupation	<input type="text"/>

Address and Phones Please give your *home* address. Please indicate by circling the appropriate letter whether I can leave a full message ("M"), callback number only ("C"), or no message at all ("N").

Street Address	<input type="text"/>	Home Phone	<input type="text"/>	M C N
City	<input type="text"/>	Cell Phone	<input type="text"/>	M C N
State	<input type="text"/>	Fax	<input type="text"/>	M C N
Zip	<input type="text"/>	Work Phone	<input type="text"/>	M C N
		Email	<input type="text"/>	M C N

Emergency Contact Please tell me the name of someone to contact in case of an emergency. If any information is the same in the table above, you can write "Same".

Name	<input type="text"/>	Relationship	<input type="text"/>
Street Address	<input type="text"/>	Home Phone	<input type="text"/>
City	<input type="text"/>	Cell Phone	<input type="text"/>
State	<input type="text"/>	Work Phone	<input type="text"/>
Zip	<input type="text"/>	Fax	<input type="text"/>
		Email	<input type="text"/>

Insurance Although I do not participate with any insurance companies, it is often helpful to me to have your insurance information in case you need tests or hospitalization.

Primary Plan Subscriber	<input type="text"/>	Secondary Plan Subscriber	<input type="text"/>
Policy #	<input type="text"/>	Policy #	<input type="text"/>
Group #	<input type="text"/>	Group #	<input type="text"/>
Phone	<input type="text"/>	Phone	<input type="text"/>

Referral source Please tell me who suggested that you see me.

Name	<input type="text"/>	Phone	<input type="text"/>
Address	<input type="text"/>	Fax	<input type="text"/>
		Relationship to you	<input type="text"/>

Pharmacies Please provide contact information for pharmacies you plan to use to fill your prescriptions.

Pharmacy Location	<input type="text"/>	Phone	<input type="text"/>
		Fax	<input type="text"/>
Pharmacy Location	<input type="text"/>	Phone	<input type="text"/>
		Fax	<input type="text"/>

Doctors and Therapists

Instructions Please provide contact information for *all* doctors (including psychiatrists and therapists) whom you see regularly. Please *also* include *past psychiatrists and therapists*. Continue on back if necessary.

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Name	
Phone	
Fax	
Type of doctor	

Is this a past or current doctor? <input type="checkbox"/> Current <input type="checkbox"/> Past
When did you last see?

Jennifer Teitelbaum Palmer M.D.
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 Baltimore MD 21211

Medical History

Medical problems Please list all major medical problems and treatments. For example: diabetes, diet & medication; breast cancer, lumpectomy & radiation. *Please include head injuries.* Continue on back if necessary.

Problem	When diagnosed	Treatment(s)	Date(s) of Treatment(s)

Surgeries Please list any operations you have had, when and why. For example: appendectomy, 1990, appendicitis. (No need to repeat operations listed above.) Continue on back if necessary.

Operation	Date	Reason

Allergies & Bad Reactions Please list any medications or foods to which you have had a bad reaction (rash, e.g.). Please include any problems with anesthesia. Continue on back if necessary.

Medication or Food	Reaction

Current Medications & Supplements Please list *all* medications and supplements that you take. Include drugs that are prescribed by a doctor, vitamins and herbal supplements, and over-the-counter drugs you take frequently. Continue back if necessary.

Medication or Supplement	Dose	Frequency	Reason you take it

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Substances Please check whether you use or have ever used any of the following, prescribed or not. Where multiple substances are listed, please circle all that apply. Continue on back if necessary.

Now	Past	Substance	Now	Past	Substance
		Alcohol			Opioids (heroin, methadone, pain medication)
		Cocaine			PCP
		Crystal meth			Stimulants/amphetamines (Ritalin, e.g.)
		Hallucinogens (ecstasy, LSD, mushrooms)			Sedatives/benzodiazepines (Xanax, e.g.)
		Inhalants (glue or paint fumes, e.g.)			Tobacco products
		Intravenous drug use			Other:
		Ketamine			Other:
		Marijuana			Other:

Symptoms & Tests Please check any of the following problems or tests you have had in the last year. If given a choice (weight loss or gain, e.g.), please circle applicable symptom(s). Where appropriate, please indicate what body part was tested (X-ray: chest, e.g.).

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swollen legs or feet	<input type="checkbox"/> Persistent rash or itching
<input type="checkbox"/> Fever	<input type="checkbox"/> Leg pain with walking	<input type="checkbox"/> Moles with changed appearance
<input type="checkbox"/> Weight loss or gain	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Lump or swelling of testicle
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Breast lump or new discharge
<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> Frequent belly pain	<input type="checkbox"/> Joint or muscle pain
<input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Limb weakness
<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Nausea and/or vomiting	<input type="checkbox"/> Persistent loss of sensation/numbness
<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Headaches
<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Constipation	<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Coordination problems
<input type="checkbox"/> Light hurts your eyes	<input type="checkbox"/> Black or tarry stools	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Light or clay-colored stools	<input type="checkbox"/> X-Ray of:
<input type="checkbox"/> Ear pain or discharge	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> CT scan of:
<input type="checkbox"/> Severe nosebleeds	<input type="checkbox"/> Jaundice (yellow skin or eyes)	<input type="checkbox"/> MRI of:
<input type="checkbox"/> Mouth ulcers	<input type="checkbox"/> Trouble urinating	<input type="checkbox"/> EKG
<input type="checkbox"/> Persistent hoarseness	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> EEG
<input type="checkbox"/> Daily cough	<input type="checkbox"/> Dark or cola-colored urine	<input type="checkbox"/> Other:
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abnormal vaginal bleeding	
<input type="checkbox"/> Asthma/wheezing	<input type="checkbox"/> Missed menstrual periods	
<input type="checkbox"/> Chest pain/discomfort	<input type="checkbox"/> Vaginal/penile discharge	<input type="checkbox"/> Other:
<input type="checkbox"/> Skipped/irregular heartbeat	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Fainting episode/black-out	<input type="checkbox"/> Easy bruising or bleeding	

Psychiatric History

Hospitalizations Please list any *psychiatric* hospitalizations you have had. Continue on back if necessary.

Hospital	When admitted/discharged	Reason hospitalized

Past Medications Please check any of the following medications that you have taken in the past.

<input type="checkbox"/> Abilify	<input type="checkbox"/> dextroamphetamine	<input type="checkbox"/> methylphenidate	<input type="checkbox"/> sertraline
<input type="checkbox"/> Adderall	<input type="checkbox"/> diazepam	<input type="checkbox"/> mirtazapine	<input type="checkbox"/> Serzone
<input type="checkbox"/> alprazolam	<input type="checkbox"/> divalproex sodium	<input type="checkbox"/> Moban	<input type="checkbox"/> Sinequan
<input type="checkbox"/> amitriptyline	<input type="checkbox"/> doxepin	<input type="checkbox"/> molindone	<input type="checkbox"/> Stelazine
<input type="checkbox"/> amoxapine	<input type="checkbox"/> duloxetine	<input type="checkbox"/> Nardil	<input type="checkbox"/> Surmontil
<input type="checkbox"/> amphetamine	<input type="checkbox"/> Effexor	<input type="checkbox"/> Navane	<input type="checkbox"/> Tegretol
<input type="checkbox"/> Anafranil	<input type="checkbox"/> Elavil	<input type="checkbox"/> nefazodone	<input type="checkbox"/> Tenormin
<input type="checkbox"/> aripiprazole	<input type="checkbox"/> escitalopram	<input type="checkbox"/> Neurontin	<input type="checkbox"/> thioridazine
<input type="checkbox"/> Asendin	<input type="checkbox"/> Eskalith	<input type="checkbox"/> Norpramin	<input type="checkbox"/> thiothixene
<input type="checkbox"/> atenolol	<input type="checkbox"/> fluoxetine	<input type="checkbox"/> nortriptyline	<input type="checkbox"/> Thorazine
<input type="checkbox"/> Ativan	<input type="checkbox"/> fluphenazine	<input type="checkbox"/> olanzapine	<input type="checkbox"/> Tofranil
<input type="checkbox"/> bupropion	<input type="checkbox"/> fluvoxamine	<input type="checkbox"/> oxazepam	<input type="checkbox"/> Topamax
<input type="checkbox"/> BuSpar	<input type="checkbox"/> gabapentin	<input type="checkbox"/> paliperidone	<input type="checkbox"/> topiramate
<input type="checkbox"/> buspirone	<input type="checkbox"/> Geodon	<input type="checkbox"/> Pamelor	<input type="checkbox"/> Tranxene
<input type="checkbox"/> carbamazepine	<input type="checkbox"/> Haldol	<input type="checkbox"/> Parnate	<input type="checkbox"/> tranylecypromine
<input type="checkbox"/> Celexa	<input type="checkbox"/> haloperidol	<input type="checkbox"/> paroxetine	<input type="checkbox"/> trazodone
<input type="checkbox"/> Centrax	<input type="checkbox"/> imipramine	<input type="checkbox"/> Paxil	<input type="checkbox"/> trifluoperazine
<input type="checkbox"/> chlordiazepoxide	<input type="checkbox"/> Inderal	<input type="checkbox"/> pemoline	<input type="checkbox"/> Trilafon
<input type="checkbox"/> chlorpromazine	<input type="checkbox"/> Invega	<input type="checkbox"/> perphenazine	<input type="checkbox"/> trimipramine
<input type="checkbox"/> citalopram	<input type="checkbox"/> Klonopin	<input type="checkbox"/> phenelzine	<input type="checkbox"/> Valium
<input type="checkbox"/> clomipramine	<input type="checkbox"/> Lamictal	<input type="checkbox"/> prazepam	<input type="checkbox"/> valproic acid
<input type="checkbox"/> clonazepam	<input type="checkbox"/> lamotrigine	<input type="checkbox"/> Pristiq	<input type="checkbox"/> venlafaxine
<input type="checkbox"/> clorazepate	<input type="checkbox"/> Librium	<input type="checkbox"/> Prolixin	<input type="checkbox"/> Vivactil
<input type="checkbox"/> clozapine	<input type="checkbox"/> Lexapro	<input type="checkbox"/> propranolol	<input type="checkbox"/> Wellbutrin
<input type="checkbox"/> Clozaril	<input type="checkbox"/> lithium	<input type="checkbox"/> protriptyline	<input type="checkbox"/> Xanax
<input type="checkbox"/> Concerta	<input type="checkbox"/> Lithobid	<input type="checkbox"/> Prozac	<input type="checkbox"/> ziprasidone
<input type="checkbox"/> Cylert	<input type="checkbox"/> Lithonate	<input type="checkbox"/> quetiapine	<input type="checkbox"/> Zoloft
<input type="checkbox"/> Cymbalta	<input type="checkbox"/> Lithotabs	<input type="checkbox"/> Remeron	<input type="checkbox"/> Zyprexa
<input type="checkbox"/> Depakene	<input type="checkbox"/> lorazepam	<input type="checkbox"/> Risperdal	<input type="checkbox"/> Other:
<input type="checkbox"/> Depakote	<input type="checkbox"/> loxapine	<input type="checkbox"/> risperidone	<input type="checkbox"/> Other:
<input type="checkbox"/> desipramine	<input type="checkbox"/> Loxitane	<input type="checkbox"/> Ritalin	<input type="checkbox"/> Other:
<input type="checkbox"/> desvenlafaxine	<input type="checkbox"/> Luvox	<input type="checkbox"/> Serax	<input type="checkbox"/> Other:
<input type="checkbox"/> Desyrel	<input type="checkbox"/> Mellaril	<input type="checkbox"/> Serentil	<input type="checkbox"/> Other:
<input type="checkbox"/> Dexedrine	<input type="checkbox"/> mesoridazine	<input type="checkbox"/> Seroquel	<input type="checkbox"/> Other:

Recent Symptoms Please check any of the following problems that you have had in the last month.

<input type="checkbox"/> Sad OR don't care	<input type="checkbox"/> Trouble at work	<input type="checkbox"/> Cutting/hurting self	<input type="checkbox"/> Hearing or seeing things
<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Interacting less	<input type="checkbox"/> Too much energy	<input type="checkbox"/> Need to count things
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Can't make decisions	<input type="checkbox"/> Impulsive behavior	<input type="checkbox"/> Check things too much
<input type="checkbox"/> Poor energy	<input type="checkbox"/> Don't enjoy things	<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Poor motivation	<input type="checkbox"/> Not good at things	<input type="checkbox"/> Lots of new plans	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Sleeping less	<input type="checkbox"/> Guilt over bad deeds	<input type="checkbox"/> Don't trust people	<input type="checkbox"/> Afraid of/avoid things
<input type="checkbox"/> Sleeping too much	<input type="checkbox"/> Deserve punishment	<input type="checkbox"/> Thoughts not your own	<input type="checkbox"/> Can't throw things away
<input type="checkbox"/> Trouble getting started	<input type="checkbox"/> Worry about health	<input type="checkbox"/> Thoughts being blocked	<input type="checkbox"/> Afraid to get fat
<input type="checkbox"/> Not getting out	<input type="checkbox"/> Worthless/hopeless	<input type="checkbox"/> Thoughts being heard	<input type="checkbox"/> Not eating to lose weight
<input type="checkbox"/> Irritability	<input type="checkbox"/> Life not worth living	<input type="checkbox"/> Messages from TV/radio	<input type="checkbox"/> Making yourself vomit
<input type="checkbox"/> Interpersonal trouble	<input type="checkbox"/> Thoughts of suicide	<input type="checkbox"/> Alien force moving your body	<input type="checkbox"/> Using exercise or laxatives to lose weight

Family Psychiatric History

Family History Have any of your blood relatives been diagnosed with a mental illness? Please indicate their relationship to you and check all that apply. Continue on back if necessary.

Relationship to you	Gender	Diagnosis (check all that apply)		Treatment (check all that apply if known)
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Major depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:	<input type="checkbox"/> therapy/counseling <input type="checkbox"/> medication <input type="checkbox"/> hospitalization

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Family Suicide History Please list all of your blood relatives who committed suicide.

Relationship to you	Age at suicide	Gender
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female

Women's History Questions (for female patients only)

Female Family History Have any of your female blood relatives suffered from mental illness beginning *within one year* of giving birth? Please check all that apply. (**One** relative per row please.)

Relationship to you		Diagnosis (check all that apply)	
<input type="checkbox"/> Mother	<input type="checkbox"/> Cousin from mother's side	<input type="checkbox"/> Major depression	<input type="checkbox"/> Other:
<input type="checkbox"/> Sister	<input type="checkbox"/> Cousin from father's side	<input type="checkbox"/> Bipolar disorder	
<input type="checkbox"/> Father's mother	<input type="checkbox"/> Aunt from mother's side	<input type="checkbox"/> Anxiety disorder	
<input type="checkbox"/> Mother's mother	<input type="checkbox"/> Aunt from father's side	<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Mother	<input type="checkbox"/> Cousin from mother's side	<input type="checkbox"/> Major depression	<input type="checkbox"/> Other:
<input type="checkbox"/> Sister	<input type="checkbox"/> Cousin from father's side	<input type="checkbox"/> Bipolar disorder	
<input type="checkbox"/> Father's mother	<input type="checkbox"/> Aunt from mother's side	<input type="checkbox"/> Anxiety disorder	
<input type="checkbox"/> Mother's mother	<input type="checkbox"/> Aunt from father's side	<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Mother	<input type="checkbox"/> Cousin from mother's side	<input type="checkbox"/> Major depression	<input type="checkbox"/> Other:
<input type="checkbox"/> Sister	<input type="checkbox"/> Cousin from father's side	<input type="checkbox"/> Bipolar disorder	
<input type="checkbox"/> Father's mother	<input type="checkbox"/> Aunt from mother's side	<input type="checkbox"/> Anxiety disorder	
<input type="checkbox"/> Mother's mother	<input type="checkbox"/> Aunt from father's side	<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Mother	<input type="checkbox"/> Cousin from mother's side	<input type="checkbox"/> Major depression	<input type="checkbox"/> Other:
<input type="checkbox"/> Sister	<input type="checkbox"/> Cousin from father's side	<input type="checkbox"/> Bipolar disorder	
<input type="checkbox"/> Father's mother	<input type="checkbox"/> Aunt from mother's side	<input type="checkbox"/> Anxiety disorder	
<input type="checkbox"/> Mother's mother	<input type="checkbox"/> Aunt from father's side	<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Mother	<input type="checkbox"/> Cousin from mother's side	<input type="checkbox"/> Major depression	<input type="checkbox"/> Other:
<input type="checkbox"/> Sister	<input type="checkbox"/> Cousin from father's side	<input type="checkbox"/> Bipolar disorder	
<input type="checkbox"/> Father's mother	<input type="checkbox"/> Aunt from mother's side	<input type="checkbox"/> Anxiety disorder	
<input type="checkbox"/> Mother's mother	<input type="checkbox"/> Aunt from father's side	<input type="checkbox"/> Schizophrenia	

Menstrual History

How old were you when you got your first menstrual period?	Age: _____
Have your cycles been mostly regular?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have regular cycles now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When was your last menstrual period? (If peri- or post-menopausal please give approximate date)	_____/_____/_____

Reproductive Events Please indicate the number of events and year(s) they occurred as applicable.

Event	Number	When occurred
Pregnancies resulting in live birth		
Miscarriages		
Elective abortions		
Stillbirths or loss of baby 20-40 weeks gestation		

Reproductive Treatments

Have you ever taken birth control pills or other hormone treatments (to treat infertility or polycystic ovaries e.g., or hormone replacement therapy)? If yes, what treatments?	[] Yes [] No
Any mood changes (better or worse) with these medications? If yes, please describe (continue on back if necessary):	[] Yes [] No

Premenstrual Symptoms Have you (and how severely) experienced any of the following symptoms which start *before* your period and *stop* within a few days of bleeding?

Symptom	No	Mild	Moderate	Severe
Anger/irritability				
Anxiety/tension				
Tearful/increased sensitivity to rejection				
Depressed mood/hopelessness				
Decreased interest in usual activities				
Difficulty concentrating				
Fatigue/lack of energy				
Overeating/food cravings				
Insomnia				
Needing more sleep than usual				
Feeling overwhelmed/out of control				
Elation, increased energy/activity, or needing less sleep				
Recurrent, unwanted, intrusive ideas, images or impulses that seem silly or horrible				
Need to check things or repeat things over and over to prevent bad things from happening				
Panic attacks				
Physical symptoms: breast tenderness, headaches, joint/muscle pain, bloating, weight gain				

If yes to any of the above, do these symptoms occur with every cycle? (Please circle) **Y** **N**

How badly have these symptoms interfered with:

	Not at all	Mild	Moderate	Severe
Your work efficiency?				
Your relationships with coworkers?				
Your relationships with your family?				
Your social life activities?				
Your home responsibilities?				

Post-Partum Mood Symptoms

Have you experienced mood symptoms that started within 4 weeks of delivery or pregnancy termination? If yes please describe (continue on back if necessary):	[] Yes [] No
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Perimenopausal Mood Symptoms

Have you experienced mood symptoms coinciding with changes in your menstrual cycle such as new cycle irregularity or hot flashes? If yes, please describe (continue on back if necessary):	[] Yes [] No
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