***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**:

**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 48 hours in advance of your appointment.

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

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

**Current Psychiatric Medications -** Medication Name/Reason for Taking/Dose/Time of Day/Start Date/Prescriber/Medication Response (Side Effects, Benefits)

**Past Psychiatric Medications -** Medication Name/Reason for Taking/Dose/Time of Day/Start Date/Prescriber/ Medication Response (Side Effects, Benefits)

**Current Non-Psychiatric Medications -** Medication Name/Reason for Taking/Dose/Time of Day/Start Date/Prescriber/ Medication Response (Side Effects, Benefits)

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

**Other Allergies:**

**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: