Premier Health
Premier Physician Network

New Patient Questionnaire

Douglas Songer, MD
4301 State Route 725
Suite B
Bellbrook, Ohio 45305

Name: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____/_____/____ Referred by: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

PLEASE COMPLETE QUESTIONNAIRE ABOUT YOUR BACKGROUND AND HISTORY

1. What is the reason you are requesting an appointment?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. Does another family member or friend see Dr. Songer? ☐ Yes ☐ No

If so, name: _____ Phone number: _____

PSYCHIATRIC HISTORY

1. Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
   Please list facility/dates:

_____

_____

_____

_____

2. Have you ever attempted suicide? ☐ Yes ☐ No
   Please describe:

_____

_____

_____

3. Are you currently working with a psychiatrist, psychotherapist, psychologist, or counselor? ☐ Yes ☐ No
   Please list who, when, and how often:

_____

_____

_____

4. Have you been treated by a psychiatrist? ☐ Yes ☐ No
   If prescribed medication, please list medication, strength, and directions:

_____

_____

_____

_____

5. Is there a history of depression, anxiety or other "nerve problems" in your family? ☐ Yes ☐ No
   If so, please list their relationship to you and diagnosis, if known:

_____

_____

_____

6. Is there a history of alcohol or substance abuse in your family? ☐ Yes ☐ No
   If so, please list their relationship to you and diagnosis, if known:

_____

_____

_____

MEDICAL HISTORY

1. Who is your primary care physician (family doctor)?

Name:_____ Phone:_____

Address: _____

2. Do you have medical problems? ☐ Yes ☐ No

If so, please list the diagnosis, current status of the condition, treatment received, and physician treating (if other than your primary care physician):

_____

_____

_____

Please list all medications, strength, and frequency:

_____

_____

_____

3. Do you use herbal products? ☐ Yes ☐ No

If so, what type and how much:

_____

_____

_____

4. Have you had any surgeries? ☐ Yes ☐ No

If so, please describe:

_____

_____

_____

5. Are you allergic to any medications? ☐ Yes ☐ No

If so, please indicate the name of the medication and the type of reaction:

_____

_____

6. Is there a history of medical illness that runs in your family? ☐ Yes ☐ No

If so, please list their relationship to you and diagnosis, if known:

_____

_____

_____

EMPLOYMENT

1. Employer:_____

Job title:_____

Years employed:_____

MARITAL STATUS

Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐

1. Describe each relationship (years/why divorced etc.), if applicable:

_____

_____

2. Do you have children? ☐ Yes ☐ No

Age? Male or female?

_____

_____

_____

3. If you have children, do they live with you? ☐ Yes ☐ No

What is your relationship like with your children:

_____

_____

_____

BACKGROUND

1. Where were you born and raised?

_____

_____

2. How long have you lived in this area?

_____

_____

3. What ethnic group do you see yourself as part of?

_____

_____

BACKGROUND

4. Please describe your childhood:

_____

_____

_____

5. Did your parents divorce? ☐ Yes ☐ No

If so, who had custody:_____

6. Did your parent(s) remarry? ☐ Yes ☐ No

If so, please describe:_____

7. Is your father living? ☐ Yes ☐ No

How old is/was he? _____

What type of work did/does he do?_____

What is/was he like as a person?_____

Were/are you close?_____

8. Is your mother living? ☐ Yes ☐ No

How old is/was she? _____

What type of work does/did she do?_____

What is/was she like as a person?_____

Are/were you close?_____

9. Do you have brothers and/or sisters? ☐ Yes ☐ No

How many and where are you in the birth order?_____

What is/was your relationship like with them? _____

Were there others important in your life as a child?_____

10. How far did you go in school? What degree(s) do you have?

_____

_____

11. What did you do after you left school?

_____

_____

12. Did you serve in the military? ☐ Yes ☐ No

If so, please describe:_____

OTHER

1. Have you ever been arrested or been in trouble with the law? ☐ Yes ☐ No
   If so, please describe:

_____

_____

_____

2. Have you ever used tobacco products? ☐ Yes ☐ No
   If so, what type, how much, and for how long?

_____

_____

3. Have you ever used alcohol products? ☐ Yes ☐ No
   If so, what type, how much, and for how long?

_____

_____

4. Have you experienced consequences from drinking? ☐ Yes ☐ No
   Financial _____ Medical _____ Job _____ Relationship _____ Legal _____ None _____
   If so, please describe:

_____

_____

5. Have you ever tried street drugs? ☐ Yes ☐ No
   If so, what type, how much, how often, and for how long?

_____

_____

6. Have you experienced consequences from drug use? ☐ Yes ☐ No
   Financial _____ Medical _____ Job _____ Relationship _____ Legal _____ None _____
   If so, please describe:

_____

_____

7. Do you use caffeinated beverages? ☐ Yes ☐ No
   If so, what type and how much?

_____

_____