



Carolina Aponte Urdaneta, MD, LLC
4200 Somerset Dr., Ste. 214 A
Prairie Village, KS, 66208
Tel: 913-608-9482
www.carolinaapontemd.com

Where were you born? _____

Primary Language(s): _____

Preferred Language: _____

How long have you lived in the Kansas City Metro Area? _____

Emergency Contact:

Name: _____ Relationship: _____

Home: (____) _____ - _____ Cell: (____) _____ - _____

Reason for Referral:

Who referred you to this office? _____

What are the problems for which you are seeking help? _____

Why seek help now? _____

What goal(s) do you expect psychiatric treatment will help you achieve? _____

How long do you expect this treatment to take? _____

What kind of treatment do you expect? (Talk therapy, medication, both, other): _____



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MEDICAL HISTORY:

Have you ever suffered from any of the following conditions? (Circle all that apply):

- Neurological:** Frequent falls, Seizures, Frequent headaches, Tics, Dystonias, Parkinson's disease, Dementia, Delirium, Stroke, Multiple Sclerosis, Encephalitis, Meningitis
- Head:** Blurry Vision, Dizziness, Seasonal Allergies, Hearing loss, Frequent sinus infections
- Heart:** Hypertension, Arrhythmias, Frequent shortness of breath, Palpitations, Frequent chest pain, Heart failure, Heart murmur, Mitral valve prolapse, Endocarditis, Heart attack, Swollen legs
- Lungs:** Asthma, Obstructive Sleep Apnea (OSA), Chronic cough, Emphysema, Chronic Bronchitis, Sarcoidosis, Tuberculosis (TB)
- Gastrointestinal:** Reflux disease (GERD), Frequent heartburn, Ulcers, Chronic diarrhea or constipation, Frequent stomachaches, Irritable bowel syndrome (IBS), Crohn's disease, Ulcerative Colitis, Celiac disease, Pancreatitis, Liver disease, Gallbladder disease
- Urinary:** Benign prostatic hypertrophy (BPH), Frequent blood in urine, Kidney failure, Urinary tract infections (UTI), Kidney infections, Kidney stones, Sexually transmitted disease (STD), Sexual dysfunction, Premenstrual syndrome (PMS), Premenstrual dysphoric disorder (PMDD), Polycystic ovary syndrome (PCOS), Infertility
- Musculoskeletal:** Chronic back pain, Fibromyalgia, Chronic joint pain, Arthritis, Gout, Osteoporosis, A significant bone fracture
- Skin:** Eczema, Severe or persistent rash, Psoriasis, Bed sores, Cellulitis
- Immunologic:** Cancer, HIV, Hepatitis B, Hepatitis C, Lupus, Lyme disease
- Endocrine:** Diabetes, Hypothyroidism, Hyperthyroidism, Elevated Cholesterol, Elevated Triglycerides, Obesity



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Do you suffer from any other chronic illness not listed above? (Please list): _____

Who is your current Primary Care Physician? _____

Date of your last physical exam? _____

SURGICAL HISTORY: (Please list all surgeries with approximate dates)

Accidents:

Have you ever sustained any significant head injury? Y N

When did the head injury (ies) occur? _____

How did the head injury (ies) happen? _____

Did you lose consciousness? Y N For how long? _____

CURRENT MEDICATIONS: (Please include all prescription drugs as well as over the counter medications, vitamins and supplements – Use the back of this page if needed)

Name	Indication	Dosage	Duration of Treatment	Side Effects



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ALLERGIES: _____

PAST MENTAL HEALTH HISTORY:

Have you ever received psychiatric treatment? Y N

If yes, please describe any intervention you have previously received: _____

Please list prior diagnoses: _____

Please indicate if you have received any of the following treatments and their effectiveness:

Type of Therapy	Level of Improvement with Therapy		
Psychodynamic Psychotherapy	Much	Some	None
Psychoanalysis	Much	Some	None
Cognitive Behavioral Therapy (CBT)	Much	Some	None
Dialectical Behavior Therapy (DBT)	Much	Some	None
Interpersonal Therapy (IPT)	Much	Some	None
Family/ Couples Therapy	Much	Some	None
Other _____	Much	Some	None



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Have you ever been hospitalized for a psychiatric condition? Y N

If yes, please specify dates and circumstances:

Name of Institution where admitted	Approximate dates	Circumstances that lead to hospitalization

Please list, to the best of your recollection, any and all psychiatric medications you have ever taken (Use the back of this paper if necessary):

Name	Indication	Dosage	Duration of Treatment	Side Effects



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FAMILY HISTORY: (Please list any blood relatives who currently struggle with or have been treated for any mental illness and/ or psychological, emotional or behavioral difficulties or problems with use or abuse of substances such as alcohol or drugs.)

Relationship to You	List of Disorders

Do medical illnesses run in your family? (E.g. seizures, thyroid problems, etc.) Y N

If yes, please list the illness and the family members that suffer from this illness: _____

SOCIAL HISTORY AND PERSONAL HABITS:

Have you ever served in the Armed Forces, active duty or reserve? Y N

Have you ever experienced or witnessed a traumatic event such as combat, rape, sexual abuse, physical abuse, or any other extremely upsetting incident? Y N

How many cups, glasses, or cans of caffeinated products do you drink per day? _____



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How many glasses, cans, or bottles of alcoholic beverages do you drink per month on average?

Between 1- 3 Between 3- 10 Between 10- 20
 Between 20- 40 More than 40

Have you ever tried to cut down your use of alcohol? Y N

Have you ever felt guilty about using alcohol? Y N

How often do you gamble? (Sports betting, racetrack, cards, casino, etc.): _____

Do you smoke? Y N If yes, how much do you smoke per week? _____

Have you ever overused/ abused any street drugs, prescription drugs or over the counter medications? Y N

If yes, please explain: _____

Have you ever used anabolic steroids? Y N

Is anyone that you are in a close relationship with abusing drugs and/or alcohol? Y N

What activities do you engage in regularly for fun? _____

Do you exercise regularly? Y N How frequently? _____

What do you typically do to de-stress? _____

Please describe your sleep (circle all that apply):

Excessive Restless Restful Poor Difficulties initiating sleep
 Nighttime awakenings No difficulties



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Work:

Are you currently employed? Y N Occupation: _____

How long have you been with your current employer? _____

How would you describe your current level of job satisfaction?

Very satisfied Satisfied Average Dissatisfied Very dissatisfied

If you are not currently employed, which of the following describes you? (check all that apply)

Retired Stay at home parent Looking for work
 Student Caring for sick / elderly relative Other

OTHER: Please share any additional information or concerns that you think may be relevant for your initial visit.
