**Patient Name:**
**Date Form Completed:**

## HISTORY OF PRESENTING PROBLEM

Have you been experiencing any mental or nervous problems in the last month?
Yes ___No___ If yes, describe:_____

_____

When did your mental problems first begin?_____

_____

_____

Have you been experiencing any physical problems in the last month?
Yes___No___ If yes, describe:_____

_____

When did your physical problems first begin?_____

## ACTIVITIES OF DAILY LIVING

What time do you get up in the morning?_____ What time do you go to bed at night? _____ Do you drive your car or truck?_____ Do you use a checkbook?_____ Who pays your bills?_____ Who cleans your home?_____Who fixes your meals?_____ Do you attend church?_____ How often?_____ What hobbies do you now have?_____What TV shows are presently your favorite? _____Can you dress yourself?_____ Can you bathe yourself or shower yourself?_____

## PAST PSYCHIATRIC HISTORY

Have you ever been hospitalized for psychiatric, drug abuse, alcohol, or mental problems? Yes____No___ If yes, please explain below:

| Psychiatric Hospital Admissions | Year Hospitalized | Hospital Name | Treating Physician or Psychiatrist | Diagnosis or Reason for Admission | Type of Treatment Received |
|---|---|---|---|---|---|
| 1st Admission | | | | | |
| 2nd Admission | | | | | |
| 3rd Admission | | | | | |
| 4th Admission | | | | | |

Have you ever been discharged from any hospital Against Medical Advice (AMA)?
Yes_____No_____
If yes, describe:_____

Have you ever had shock treatments (ECT)? Yes____No____ If yes, describe when and where:_____

Have you ever been advised by any doctor or health practitioner to get mental or psychological treatment? Yes___No___ If yes, describe:_____

_____

Have you ever been legally committed or admitted involuntarily to a mental hospital or psychiatric unit? Yes_____No_____
If yes, describe:_____

Have you ever had episodes of racing thoughts, hyperactivity, elevated or irritable mood, not needed sleep and impulsive behaviors? Yes_____No_____
If yes, when and describe:_____

_____

_____

Have you ever refused mental treatment when recommended by a doctor?
Yes__No___

If yes, describe:_____

Have you ever received any type of office treatment by your family doctor, psychiatrist, psychologist or therapist (medication, counseling, therapy) for any nervous condition, psychological, psychiatric, family, or marital problems?
Yes__No___ If yes, describe below:

| Year of Treatment | Treating Therapist/Physician | Diagnosis or Problem | Type of Treatment (e.g. drugs, therapy) |
|---|---|---|---|
| | | | |

Have you ever intentionally overdosed yourself on drugs or medications? Yes___ No___
If yes, describe:_____

Have you ever attempted to take your life? Yes_____No____ If yes, describe:_____

_____

**Patient Name:**
**Date Form Completed:**

Have you ever intentionally cut, burned or disfigured yourself? Yes_____No_____
If yes, describe:_____

Do you have a history of an eating disorder, bulimia or anorexia? Yes_____ No___
If yes, describe:_____

As a child, did you have trouble sitting still in school? Yes_____No_____
Did you have trouble learning in school? Yes_____No_____
Did you have trouble keeping your mind on things as a child? Yes_____No_____
Did you have trouble learning to read? Yes_____No_____
Did teachers complain you were too active? Yes_____No_____

## PSYCHIATRIC MEDICATION HISTORY

If you have ever been prescribed any form of psychiatric medication, please review this list and place a checkmark by those medications you have taken. Please indicate anything you can recall about the dosage, length and time of treatment, response, and side effects.

| Medication Brand (Generic) | Max dose (mg) | Length of Treatment & Year(s) Taken | Response | Side Effects |
|---|---|---|---|---|
| **ANTI-DEPRESSANTS** | | | | |
| ❑ Anafranil (clomipramine) | | | | |
| ❑ Ascendin (amoxapine) | | | | |
| ❑ Brintellix (vortioxetine) | | | | |
| ❑ Celexa (citalopram) | | | | |
| ❑ Cymbalta (duloxetine) | | | | |
| ❑ Desyrel (trazodone) | | | | |
| ❑ Effexor (venlafaxine) | | | | |
| ❑ Elavil (amitriptyline) | | | | |
| ❑ Emsam (selegiline) | | | | |
| ❑ Fetzima (levomilnacipran) | | | | |
| ❑ Lexapro (escitalopram) | | | | |
| ❑ Luvox (fluvoxamine) | | | | |
| ❑ Nardil (phenelzine) | | | | |
| ❑ Norpramin (desipramine) | | | | |
| ❑ Pamelor (nortriptyline) | | | | |
| ❑ Parnate (tranylcypromine) | | | | |
| ❑ Pexeva (paroxetine) | | | | |
| ❑ Paxil (paroxetine) | | | | |
| ❑ Pristiq (desvenlafaxine) | | | | |
| ❑ Prozac (fluoxetine) | | | | |
| ❑ Remeron (mirtazapine) | | | | |
| ❑ SamE | | | | |
| ❑ Serzone (nefazadone) | | | | |
| ❑ Sinequan (doxepin) | | | | |
| | | | | |

**Patient Name:**
**Date Form Completed:**

| Medication Brand (Generic) | Max dose (mg) | Length of Treatment & Year(s) Taken | Response | Side Effects |
|---|---|---|---|---|
| ❑ St. John's Wort (hypericum) | | | | |
| ❑ Tofranil (imipramine) | | | | |
| ❑ Trintellix (vortioxetine) | | | | |
| ❑ Viibryd (vilazodone) | | | | |
| ❑ Vivactil (protriptyline) | | | | |
| ❑ Wellbutrin (buproprion) | | | | |
| ❑ Zoloft (sertraline) | | | | |
| **MOOD STABILIZERS** | | | | |
| ❑ Depakote (valproic acid) | | | | |
| ❑ Gabitril (tiagabine) | | | | |
| ❑ Keppra (levetiracetam) | | | | |
| ❑ Lamictal (lamotrigine) | | | | |
| ❑ Lithium, Eskalith, Lithobid | | | | |
| ❑ Neurontin (gabapentin) | | | | |
| ❑ Symbyax | | | | |
| ❑ Tegretol (carbamazepine) | | | | |
| ❑ Topamax (topiramate) | | | | |
| ❑ Trileptal (oxcarbazepine) | | | | |
| **NEUROLEPTICS** | | | | |
| ❑ Abilify (aripiprazole) | | | | |
| ❑ Clozaril (clozapine) | | | | |
| ❑ Fanapt (iloperidone) | | | | |
| ❑ Geodon (ziprasidone) | | | | |
| ❑ Haldol (haloperidal) | | | | |
| ❑ Invega (paliperidone) | | | | |
| ❑ Latuda (lurasidone) | | | | |
| ❑ Loxitane (loxapine) | | | | |
| ❑ Mellaril (thioridazine) | | | | |
| ❑ Moban (molindone) | | | | |
| ❑ Navane (thiothixene) | | | | |
| ❑ Prolixin (fluphenazine) | | | | |
| ❑ Rexulti (brexpiprazole) | | | | |
| ❑ Risperdal (risperidone) | | | | |
| ❑ Saphris (asenapine) | | | | |
| ❑ Serentil (mesoridazine) | | | | |
| ❑ Seroquel (quetiapine) | | | | |
| ❑ Stelazine (trifluoperazine) | | | | |
| ❑ Thorazine (chlorpromazine) | | | | |
| ❑ Trilafon (perphenazine) | | | | |
| ❑ Vraylar (cariprazine) | | | | |
| ❑ Zyprexa (olanzapine) | | | | |
| **ANTI-ANXIETY AGENTS** | | | | |
| ❑ Ativan (lorazepam) | | | | |
| ❑ BuSpar (buspirone) | | | | |
| ❑ Kava Kava | | | | |
| ❑ Klonopin (clonazepam) | | | | |

**Patient Name:**
**Date Form Completed:**

| Medication Brand (Generic) | Max dose (mg) | Length of Treatment & Year(s) Taken | Response | Side Effects |
|---|---|---|---|---|
| ❑ Librium (chlordiazepoxide) | | | | |
| ❑ Serax (oxazepam) | | | | |
| ❑ Tranxene (clorazepate) | | | | |
| ❑ Valerian | | | | |
| ❑ Valium (diazepam) | | | | |
| ❑ Vistaril, Atarax (hydroxyzine) | | | | |
| ❑ Xanax (alprazolam) | | | | |
| **PSYCHOSTIMULANTS** | | | | |
| ❑ Adderall (dextroamphetamine & amphetamine) | | | | |
| ❑ Concerta (methylphenidate) | | | | |
| ❑ Cylert (pemoline) | | | | |
| ❑ Daytrana (methylphenidate patch) | | | | |
| ❑ Dexedrine (dextroamphetamine) | | | | |
| ❑ Focalin (dexmethylphenidate) | | | | |
| ❑ Intunive (guanfacine XR) | | | | |
| ❑ Nuvigil (modatinil) | | | | |
| ❑ Provigil (modafinil) | | | | |
| ❑ Quillivant (methylphenidate hydrochloride) | | | | |
| ❑ Ritalin (methylphenidate) | | | | |
| ❑ Strattera (atomoxetine) | | | | |
| ❑ Vyvanse (lisdexamfetamine) | | | | |
| **SLEEPING AGENTS** | | | | |
| ❑ Ambien (zolpidem) | | | | |
| ❑ Dalmane (flurazepam) | | | | |
| ❑ Halcion (triazolam) | | | | |
| ❑ Lunesta (eszopiclone) | | | | |
| ❑ Placidyl (ethchlorvynol) | | | | |
| ❑ Prosom (estazolam) | | | | |
| ❑ Restoril (temazepam) | | | | |
| ❑ Rozerem (ramelteon) | | | | |
| ❑ Somnote (chloral hydrate) | | | | |
| ❑ Sonata (zaleplon) | | | | |
| **OTHER** | | | | |
| ❑ Nuedexta (dextromethorphan hbr & quinidine sulfate) | | | | |
| ❑ Vivitrol (naltrexone) | | | | |
| ❑ Qsymia (phentermine & topiramate | | | | |

**Patient Name:**
**Date Form Completed:**

## SUBSTANCE USE HISTORY

Do you use alcohol now? Yes___No___ Not now but in the past_____ If yes to any use of alcohol then describe below:

Type of alcohol (whiskey, beer, wine, etc.):_____
Number of alcohol drinks you have or had per day: _____
When did you start using alcohol; when did you stop?_____
Describe any past alcohol problems in your life (DUIs, AIs, alcoholism, etc.):_____
_____
Describe any medical treatment for alcohol problems:_____
_____
Have you ever attended an AA or NA meeting? Yes__No___

Have you ever taken a medication or drug that you received from friends or family or bought off the street? Yes_____No_____
If yes, describe: _____
Have you ever used illegal drugs (marijuana, heroin, cocaine, uppers, downers, crack, etc.)? Yes___No___
Have you ever sniffed paint, glue or gasoline to get high? Yes_____No____ If yes, what did you sniff and how long?_____
Have you ever used Ecstasy, GHB, LSD, peyote, mescaline, PCP, mushrooms?
Yes__No___
If yes, what and when?_____
_____
Have you ever used illegal intravenous drugs (IV drugs)? Yes_____No___
Have you ever received treatment for drug/substance abuse? Yes_____No_____
If yes, what hospital; what year?_____
_____

If you answered yes to using any drugs, list what type of illegal drugs you have previously used:

| Drug/Substance | Age at Use | How Long Used | Last Date Used |
|---|---|---|---|
| | | | |

Do you drink coffee or tea? Yes_____No_____ How many cups per day?_____
Do you drink caffeinated soft drinks? Yes_____No____ What soft drinks?_____
_____How many per day?_____

Do you use tobacco now? Yes__No___ Not now but previously _____ If yes or have used tobacco in the past, please describe how much and when you started and when you stopped:_____

**Patient Name:**
**Date Form Completed:**

## PAST MEDICAL HISTORY

List any serious childhood illnesses you had:_____
Were you born prematurely? Yes_____No___ What did you weigh at birth?_____
Did you have growth problems? Yes___No___

List any permanent physical or mental problems from childhood:_____
_____

Check any serious illnesses you have now or have been treated for in the past and describe the illness and when you had it on the right.

_____Seizures _____
_____Cancer_____
_____Diabetes_____
_____Thyroid Disease_____
_____Anemia (Low Blood)_____
_____High Blood Pressure_____
_____Heart Disease_____
_____Lung or Breathing Problems_____
_____Joint or Back Disease_____
_____Stomach or Bowel Disease_____
_____Female Problems_____
_____Pregnancy Problems_____
_____Urinary Tract Problems_____
_____Sexual Problems_____
_____Prostate Problems_____
_____Sleep Apnea_____
_____HIV or AIDS_____
_____Other_____

If you were hospitalized for these illnesses, list the hospital(s):_____
_____
_____
_____

Have you been injured in any motor vehicle accidents? Yes_____No_____, if yes, list:

| Date | Your Age at the Time | Type of Injury | Treatment/By Whom |
|---|---|---|---|
| | | | |

Have you ever been knocked out, or had a brain injury? Yes_____No_____
If yes, describe what happened: _____

**Patient Name:**
**Date Form Completed:**

Have you ever been in a coma? Yes___No___
Have you ever broken any bones? Yes_____No____ If yes, describe which bones were broken, right or left side:_____

Primary Care Doctor:_____
List any other doctors you are seeing: _____
_____

Have you had any surgeries or operations? Yes_____No___ If yes, list below:

| Date | Your Age at the Time | Hospital Where Performed | Type of Surgery |
|---|---|---|---|
| | | | |

Are you now taking any medications? Yes____No___ If yes, please list the milligrams and how often you take your medicine.

| Medications | Milligrams | Times Per Day |
|---|---|---|
| | | |

Are you taking any over-the-counter medicines (you don't need a prescription)? Yes___ No___ If yes, list them:_____
_____
Are you taking any herbs or natural products? Yes___No___ If yes, list them:_____
_____
Who keeps track of your medications? You___, Your Spouse ____, Someone Else ___

**Patient Name:**
**Date Form Completed:**

Do you have any drug allergies? Yes___No___ If yes, list below:

| Drug | Allergic Reaction |
|---|---|
| | Rash, nausea, hives, etc. |

**Next Five Questions For Women:**

1) How many pregnancies have you had?_____ How many living children have you had?_____ How many miscarriages have you had?_____
2) Were you depressed after having a baby or miscarriage? Yes_____No_____
If yes, when?_____ Were you medically treated? Yes_____No___
3) Have you had any babies by cesarean section? Yes_____No___
4) Could you be pregnant? Yes_____No_____
5) When was your last menstrual period?_____

## FAMILY HISTORY

Please check if any of these illnesses or acts have occurred in any of your parents, brother/sisters or children; grandparents, aunts/uncles, or cousins.

_____High Blood Pressure
_____Thyroid Illnesses
_____Diabetes
_____Cancer
_____Kidney Disease
_____Liver or Gastrointestinal Disease
_____Seizures (epilepsy)
_____Neurological Disease
_____Alzheimer's Disease
_____Bipolar
_____Schizophrenia
_____Depression/Anxiety
_____Alcohol/Drug Problems
_____Eating Disorders (anorexia, bulimia)
_____Attention Deficit Disorder
_____Learning Disorder
_____Suicide
_____Killing Another Person
_____Violence Towards Others
_____Child Abuse
_____Spouse Abuse

If you checked any of the above, please explain which relative had the illness or did the violent act:_____

_____

_____

Father's age if living: _____ Mother's age if living:_____

If a relative is dead, list what your father, mother, brothers/sisters or child died of and their ages at death:_____

**Patient Name:**
**Date Form Completed:**

## SOCIAL HISTORY

Where were you born?_____
Where did you live when you were growing up?_____
_____
Where have you lived as an adult and when did you live there?_____
_____

Date of birth:_____How many children were in your family of origin? _____
Of your siblings, how many sisters? _____brothers?_____ Where do you come in the family? (1st child, last child, etc)_____

What did your father do for a living?_____
What did your mother do for a living?_____

Did your family have enough money?____not enough money?_____live in poverty?____
Is your father living?_____ Year he died?_____ Your mother?_____Year she died?____
Are (were) your parents divorced?_____ If yes, when?_____ How old were you at the time?_____Who raised you?_____
Did your parent(s) own your home? Yes_____No____Was your home life happy? Yes___No___ Abusive? Yes___No___ Threatening? Yes_____No___

Did your father abuse your mother? Yes_____No_____ If yes, explain:_____
Have you ever been sexually abused? Yes___No___ If yes, explain: _____
Have you ever been physically abused? Yes__No___ If yes, explain: _____
Are you presently being sexually or physically abused by anyone? Yes____No__
If yes, who?_____
Have you ever been violent to or harmed a person, or torn up property? Yes____No___
Have you ever shot, stabbed or beaten another person? Yes_____No___
Have you ever threatened to kill another person? Yes_____No_____
Have you ever killed another person, even if by accident? Yes____No___
Have you ever been in legal trouble for your sexual behavior? Yes_____No_____
Have you ever sexually abused or harassed a child or adult? Yes_____No_____

Highest grade you completed in school?_____
If you did not finish high school, what was the reason you quit?_____
What were your grades in high school?_____ Did you require special education classes? Yes_____No_____

In grade school or high school, did the teachers think you were hard to control or was it hard to get your attention? Yes_____No_____ If yes, explain:_____
_____

**Patient Name:**
**Date Form Completed:**

If you attended any college or trade school, list degree, diploma, date of graduation, and college/university or trade school you attended:

| Degree/Diploma/Major | Dates of Graduation | College/University/Trade School |
|---|---|---|
| | | |

How many times have you been married?_____
How many times have you been divorced?_____
Are you now divorced or married? Divorced_____ Married_____

How long have you been divorced/married?_____

**Please complete:**

| Marriage | Year Married | Year Divorced | Spouse's Name | Any natural children and their ages | Reason for divorce |
|---|---|---|---|---|---|
| 1st Marriage | | | | | |
| 2nd Marriage | | | | | |
| 3rd Marriage | | | | | |
| 4th Marriage | | | | | |

How many natural children do you have?_____ How many stepchildren do you have?_____

How would you describe your marriage if you are presently married? Good relationship_ _____, Fair relationship_____, Bad relationship_____, Terrible or abusive relationship_____

If you are not married but have a lover, describe your relationship. Good_____, Fair_ Bad__, Terrible or abusive_____

Describe your relationship with your children. Close_____, Could be better_____, Distant_____ Poor_____

If you do not have a relationship at this time, how do you feel about this? Satisfied_____ Lonely but okay_____ Not satisfied and want a relationship_____, Very sad and lonely_____.

## LEGAL HISTORY

Have you ever been in prison or jail? Yes_____No____If yes, where and when _____

Have you had any criminal felony or misdemeanor convictions, drug arrests, DUIs or public intoxication arrests? Yes_____No_____ If yes, fill in below:

| Arrest Date | Charge(s) | Where (City or State) | Were you convicted? | Length of time in prison/jail |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have you been involved in any lawsuits as either the plaintiff or defendant? Yes__No__
If yes, describe: _____
Has your spouse, or anyone else, ever gotten a restraining order or emergency protective order against you? Yes_____No____ If yes, describe_____

Have you ever been charged with spouse abuse, child abuse or neglect, or terroristic threatening? Yes_____No_____ If yes, describe:_____
Have you ever filed a workers' compensation claim? Yes___No___ If yes, what was (were) the work injury(ies)?_____

Have you ever filed for or received a bankruptcy judgment? Yes___No___

## EMPLOYMENT/VOCATIONAL HISTORY

Employment status (check one) Full Time _____, Part Time___, Unemployed____, Student_____

If not employed, reason you are not presently employed_____

If presently employed, who is your employer?_____
Employer address:_____
Describe your job duties:_____
Length of time on your last permanent job:_____
Job duties/Position of that job:_____
If you are disabled, year of and reason for your disability:_____

**Patient Name:**
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What are your present sources of all monthly income?_____

_____

Were you ever fired or asked to resign from a job? Yes_____No_____If yes, reason: ____

_____

Where is your spouse employed?_____

_____

If you are not working, do you plan to return to work at anytime in the future?
Yes_____No_____

List past employment (beginning with your most recent job):

| Employer | Job Title | Start Date | Finish Date | Reason for Leaving | Other |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## MILITARY HISTORY

Have you ever tried to enter military service or a service academy (e.g. Naval Academy, West Point)? Yes_____No_____

Have you had any military service? Yes_____No_____ If yes, then list below:

| Branch of Service | Years Served | Rank at Time of Discharge | Type of Discharge | Job Duties |
|---|---|---|---|---|
| | | | | |
| | | | | |

Were there any disciplinary actions against you? Yes_____No_____ If yes, describe:__

_____

Were you ever in the brig or stockade? Yes___No___
Where was your basic training?_____
Where was your advanced training?_____
If you ever served in a combat zone, list dates and area: _____

_____

If wounded in military service, describe:_____
Describe any military pension or disability:_____
If you have been turned down for military service or a military academy, explain why:___

_____

**Patient Name:**
**Date Form Completed:**

## REVIEW OF SYSTEMS
## (CIRCLE THOSE SYMPTOMS PRESENT)

**GENERAL:** Fever, shaking, chills, change in appetite, loss in weight, change in weight, fatigue, change in sleeping patterns, soaking night sweats.

Explain any circled items, if you have lost or gained weight, how many pounds in the last three months?

_____

_____

_____

**HEAD, EYES, EARS, NOSE, THROAT:** Headaches, changes in vision, double vision, blurred vision, eye pain, excessive tearing, discharge from the eyes, changes in hearing, ringing in ears, ear pain, discharge from ears, nosebleeds, odd odors, hoarseness, dental pain, sore tongue, sore throat, mouth sores, trouble swallowing.

Explain any circled items_____

_____

_____

_____

**CHEST:** Cough, sputum production, shortness of breath, wheezing, blood in sputum, abnormal chest x-ray, positive TB test, lump(s) in breast, nipple discharge, nipple bleeding, breast pain.

Explain any circled items:_____

_____

_____

_____

**HEART:** Chest pain with exercise, shortness of breath walking, shortness of breath upon lying down, heart murmur, rheumatic fever, shortness of breath that wakes you up at night, swelling in legs, fainting.

Explain any circled items:_____

_____

_____

**STOMACH, BOWEL:** Change in appetite, nausea, vomiting, blood in vomit, dark brown vomit, diarrhea, constipation, change in stool size, blood in stool, dark black tarry-colored stool, food intolerance, trouble swallowing, heartburn, indigestion, laxative use, excessive gas, abdomen pain, weight loss, weight gain.

Explain any circled items:_____

_____

**Patient Name:**
**Date Form Completed:**

**URINARY, GENITAL:** Trouble starting urination, excessive urination, dribbling of urine, pain upon urination, blood in urine, excessive urination after going to bed, unable to hold urine, bedwetting, sores on genitals.

Explain any circled items:_____

_____

_____

**FEMALE:** Menstrual irregularity, premenstrual distress, menopause symptoms, excessive female bleeding.

Explain any circled items:_____

_____

_____

**MENTAL:** Depression, sadness, nervousness, panic, thoughts of suicide, poor concentration, loss of memory, too happy, word-finding difficulty, confusion, inability to know month/year, hearing voices, seeing things, paranoid thoughts, irritability, excessive anger, arguing, crying for no reason, trouble thinking, flashbacks, thoughts of killing another person, counting things, checking things, afraid of germs, afraid to touch doorknobs, wash hands more than 10 times daily, take more than 2 baths or showers daily. Do you have a present plan to kill yourself? Yes__No__ Do you have a plan to kill someone else? Yes_____No_____

Explain any circled items: _____

_____

_____

_____

_____

_____

_____

**NEURO-LOGIC:** Blackouts, seizures, double vision, partial blindness, headaches, numbness, tingling, weakness, poor balance, shaking or tremors, abnormal movements of face or body, poor coordination, paralysis, loss of reflexes, pain.

Explain any circled items:_____

_____

_____

**MUSCLES SKELETAL:** Muscle spasms, joint pain, bone disorders, difficulty walking, difficulty sitting, difficulty using hands, difficulty bending, difficulty lifting.

Explain any circled items:_____

_____

_____

**SLEEP:** Cannot fall asleep, cannot stay asleep, wake up too early, fall asleep anytime, night terrors, nightmares, sleep walking, restless legs before sleep, cannot stay awake during or while sitting, severe snoring that bothers others, choking during sleep, cannot stay awake to drive, others have observed you to stop breathing during sleep, fall or stagger if angry or laugh, hear things when falling asleep or waking up, paralyzed for short time after waking up.

Explain any circled items:_____

_____

_____

**SEXUAL:** Men: Cannot get erection, cannot ejaculate, ejaculate too soon, no sexual desire, partner does not meet my needs.

Women: Cannot lubricate, cannot have orgasm, no sexual desire, partner does not meet my needs.

How many times per month do you engage in sexual activity with another person or a spouse?_____

Explain any circled items:_____

_____

**HIV:** Have you been tested for HIV? Yes____No___
Results if tested: Positive_____Negative____