**OCD History Form**

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| **Name:** | | | | |
| **Age:** | | **Date of Birth:** | | |
| **Referring Psychiatrist:** | | | | |
| **Age of Symptom Onset:** | | **Age of OCD Diagnosis:** | | |
| **Year of Symptom Onset:** | | **Year of OCD Diagnosis:** | | |
| **YBOCS Score:** | | **YBOCS date completed:** | | |
| **Education Level:** | | **Handedness: □ Right □ Left □ Ambidextrous** | | |
| **Characteristics of OCD:** | | | | |
| **Co-Morbidities** | | | | |
| **Psychosis**:  **□** Schizophrenia  **□** Schizoaffective Disorder  **□** Delusional Disorder  **□** Other | | **Anxiety**:  **□** Panic  **□** Phobia  **□** Generalized  **□** OCD  **□** Social Phobia  **□** PTSD | | |
| **OC Spectrum:**  **□** Tourette Syndrome  **□** Body Dysmorphic Disorder  **□** Trichtillomania/Dermatillomania  **□** Eating Disorder  **□** ADHD | | **Seizures: □** Yes□ No  **ETOH/Substance Abuse: □** Yes □ No **□** Ever  **□** Currently  If patient ever or currently abused, what and when?  **Personality Disorder: □** Yes **□** No  If Yes, describe: | | |
| **Other Psychiatric Diagnoses:** | |
| **Past Psychiatric/Medical History** | | | | |
| Number of Psychiatric hospitalizations: | | History of involuntary hospitalization: **□** Yes □ No | | |
| Suicide Attempts: **□** Yes □ No  How many?  Methods: | | Dates of psychiatric hospitalizations: | | |
| **Additional Medical History:** | | | | |
| **Allergies:** | | | | |
| **Surgical History:** | | | | |
| **Social History:**  **Single Married Divorced Children Lives with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Occupation:**  **Hobbies:**  **Guns in the home: Yes No**  **History of legal problems:**  **Tobacco: □ Yes □ No**. If yes, how many packs? \_\_\_\_\_ How many years?\_\_\_\_\_\_  **Alcohol: □ Yes □ No**. If yes, how much (glasses, cans, shots)? \_\_\_\_\_ Type?\_\_\_\_\_\_\_\_\_\_\_\_\_  **Illicit Drugs: □ Yes □ No**. If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_  **Caregiver/Social Issues:** | | | | |
| **Family Medical History:**  **Family History of Psychiatric Disorders:** | | | | |
| **Current Medications** | **Dose** | | **Frequency** | **Effects/Response** |
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| **Psychiatric Treatment History** | | | | |
| **Psychotherapy Tried (include provider, type, and approx. # of sessions):** | | | | |
| **Somatic Therapies:**  **ECT (Response +/-)**  Bilateral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unilateral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Transcranial magnetic Stimulation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Prior psychiatric neurosurgical treatments**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Intravenous clomipramine**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Ketamine (IV):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Ketamine (intranasal)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Notes: | | | | |

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| **Medication History** | | | | |
| **Serotonergic Medications** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
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| **Benzodiazepines** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
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| **Antipsychotics** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
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| **Other Augmenting Agents** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
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Referring Psychiatrist Signature Printed Name Date