Richard Seeber, M.D.

Adult, Perinatal, and Reproductive Psychiatry & Psychotherapy

Perinatal and Reproductive Psychiatry Supplemental Form

Date: _____

Patient Name: _____

First *Middle* *Last*

Date of Birth: _____

Obstetrician-gynecologist's or midwife's name: _____
Obstetrician-gynecologist's or midwife's address: _____
Obstetrician-gynecologist's or midwife's phone: _____

Marital status:

- Single
- Married
- Separated or divorced
- Widowed

Current occupation:

Menstrual and Gynecologic History:

1. Age at first menstruation:

2. Date of last menstrual period (LMP):

3. If LMP not known, number of months since LMP:

4. Are your menstrual cycles predictable within five days (choose one)? Yes / No
   - **If no, skip to Question 14**

5. At what age did your periods start to become irregular?

6. Have you ever skipped two or more cycles in a row?

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Menstrual and Gynecologic History, continued:

7. Have you ever gone more than 60 days without a period?

8. Longest time you have gone without a period (without being pregnant):

9. Average length of menstrual cycle in days (from first day of bleeding of one period to the first day of bleeding of the next period):

10. How many days does your period usually flow?

11. Have your periods ever stopped temporarily?

12. What caused your periods to stop and for how long? (Select from the following)
    - Sudden weight loss
    - Hormonal medication (e.g. leuprolide, danazol, nafarelin, Depo-Provera, etc.)
    - Low body fat
    - Chemotherapy or radiation treatments
    - Hysterectomy, ovaries not removed
    - Hysterectomy, ovaries removed
    - Both ovaries removed without hysterectomy
    - Natural menopause
    - Unexplained
    - Other (please specify):_____

13. For how long did you have no periods?

14. Do you usually have pain with your periods?

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Menstrual and Gynecologic History, continued:

15. Have you ever been told by a doctor that you have any of the following conditions? Please mark all that apply:
    - Sexually transmitted infection (please specify:_____)
    - Endometriosis
    - Polycystic ovarian syndrome
    - Pelvic inflammatory disease
    - Fibroid uterus
    - Fibrocystic breast disease
    - Breast cancer
    - Multiple abnormal Pap smears
    - Thyroid dysfunction

16. Do you use any form of contraception?
    - If yes, please specify which:_____

17. Have you used a birth control preparation (e.g. contraceptive pill, patch, injection) in the past?
    - If yes, please specify which:_____

18. If you currently use or have ever used a birth control preparation,
    - When did you start it?
    - For how long did you take or use it?
    - Did you experience any of the following while on a birth control preparation?
        i. Tension or irritability
        ii. Mood swings or depression

Infertility Treatment History:

1. Did you ever try for more than two years to get pregnant or have repeated problems carrying a pregnancy? (choose one) Yes / No

2. Did you ever use medications to improve your fertility? Yes / No
    - If yes, what was the name of the medication you took?:

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Pregnancy History:

1. What is your current pregnancy status? (select one)
    - Not pregnant (not trying)
    - Not pregnant (trying)
        - Are you trying using IVF?: Yes / No
    - Currently pregnant:
        - How many weeks?
        - Estimated date of delivery?
    - Postpartum (please specify how many weeks):

2. Number of previous pregnancies (including live births, terminations, miscarriages, or stillbirth):
3. Number of previous deliveries at term:
4. Number of previous preterm deliveries (before 37 weeks; please specify how many weeks at delivery):
5. Number of elective terminations:
6. Number of miscarriages or stillbirths:

If you have had a pregnancy, please complete the following information:

For your first pregnancy:
If delivered, date of delivery:

1. Did you carry your pregnancy to term?

2. Were you taking any mood or anxiety medications when you found out you were pregnant?
    a. If so, which (what medicine, what dose?):

3. Did you continue your medication through pregnancy?
    a. If no, when did you stop?
    b. How much time did you take to stop your medication?
    c. Did you start a new medication during pregnancy?
        i. If so, which? When did you start it?

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For your second pregnancy:
If delivered, date of delivery:

1. Did you carry your pregnancy to term?

2. Were you taking any mood or anxiety medications when you found out you were pregnant?
    a. If so, which (what medicine, what dose?):

3. Did you continue your medication through pregnancy?
    a. If no, when did you stop?
    b. How much time did you take to stop your medication?
    c. Did you start a new medication during pregnancy?
        i. If so, which? When did you start it?

For your third pregnancy:
If delivered, date of delivery:

1. Did you carry your pregnancy to term?

2. Were you taking any mood or anxiety medications when you found out you were pregnant?
    a. If so, which (what medicine, what dose?):

3. Did you continue your medication through pregnancy?
    a. If no, when did you stop?
    b. How much time did you take to stop your medication?
    c. Did you start a new medication during pregnancy?
        i. If so, which? When did you start it?

Additional Medical and Psychiatric History:

1. Have you taken any of the following antidepressant or antianxiety medications? (Mark all that apply):
    - Fluoxetine (Prozac)
    - Sertraline (Zoloft)
    - Paroxetine (Paxil)
    - Citalopram (Celexa)
    - Escitalopram (Lexapro)
    - Fluvoxamine (Luvox)
    - Bupropion (Wellbutrin)

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1. (Continued) Have you taken any of the following antidepressant or antianxiety medications? (Mark all that apply):
   - o Venlafaxine (Effexor)
   - o Duloxetine (Cymbalta)
   - o Vilazodone (Viibryd)
   - o Nefazodone (Serzone)

   - o Amitriptyline (Elavil)
   - o Nortriptyline (Pamelor)
   - o Imipramine (Tofranil)
   - o Clomipramine (Anafranil)

   - o Doxepin (Sinequan)
   - o Trazodone (Desyrel)
   - o Mirtazapine (Remeron)

   - o Alprazolam (Xanax)
   - o Clonazepam (Klonopin)
   - o Diazepam (Valium)
   - o Lorazepam (Ativan)
   - o Temazepam (Restoril)

   - o Lithium
   - o Valproic acid (Depakote)
   - o Carbamazpine (Tegretol)
   - o Oxcarbazepine (Trileptal)
   - o Lamotrigine (Lamictal)
   - o Topiramate (Topamax)
   - o Gabapentin (Neurontin)

   - o Haloperidol (Haldol)
   - o Chlorpromazine (Thorazine)
   - o Perphenazine (Trilafon)
   - o Olanzapine (Zyprexa)
   - o Risperidone (Risperdal)
   - o Quetiapine (Seroquel)
   - o Ziprasidone (Geodon)
   - o Aripiprazole (Abilify)
   - o Lurasidone (Latuda)

2. How many alcoholic beverages do you drink in a week?

3. How many cigarettes do you smoke in a week?

Additional Medical and Psychiatric History, continued:

4. Do you use any other substances recreationally (e.g. cannabis, opioids, stimulants not prescribed to you, benzodiazepines or sedatives not prescribed to you, cocaine, methamphetamine, hallucinogens?):
    - If yes, please specify:

5. Are there any recent life stressors that have been impacting you?

6. Do you have any active medical problems?

7. Do you have any allergies to medications?

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