The Johns Hopkins   
Reproductive Mental Health Center

Pre-Pregnancy Evaluation Questionnaire

Please answer as completely as possible. When you are finished, please email it to our administrator at [RMHCADMIN@jh.edu](mailto:RMHCADMIN@jh.edu) or fax to 410-502-3755.

Once you have returned this form we will contact you to provide you with some possible dates for your evaluation. Please check your email and respond in less than one week or your appointment slot may be given to the next patient on our waitlist.

1. Who referred you to our program?
   1. Self-Referred
   2. Provider -- NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please tell us in one to two sentences why you are seeking this evaluation?

1. Are you seeking a one-time evaluation or ongoing medication management care?
   1. One-time evaluation for pre concerption
   2. Ongoing medication management once pregnant
   3. All the above if available

(Please note that if you are looking to establish ongoing care at our clinic, this will be discussed during your initial evaluation. We cannot guarantee ongoing care as spots are limited. You should not assume that any new medications will be prescribed at your evaluation appointment or that you will be able to establish care at our clinic during your evaluation appointment.)

1. If you are interested in ongoing medication management care, are you routinely available on Thursday afternoons?
   1. YES
   2. NO
   3. OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is your preferred language?
3. Do you require an interpreter? **YES** **NO**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION FORM** | | | | | | | |
| **DEMOGRAPHICS** | | | | | | | |
| **Existing Hopkins Patient MRN:** | | | | **New Patient YES/NO** | | | |
| Full Legal Name: | | | | | | | |
| Date of birth: | | | SSN: | | | Race: | |
| Religion: | | | Country of Birth: | | | Marital Status: | |
| Address: | | | | | | | |
| City: | | | State: | | | ZIP Code: | |
| Phone: | | | Cell: | | | | |
| Male \_\_\_\_ Female\_\_\_\_\_\_ Non-Binary \_\_\_\_\_\_ Mother’s Maiden Name: | | | | | | | |
| Email: | | | | | | | |
| Preferred Pharmacy: (Name, address, phone) | | | | | | | |
| Are you employed? | | Employer Name: | | | | | Employment Status: |
| Are you a student? | | College/School Name: | | | | | Student Status: |
| **EMERGENCY:** | | | | | | | |
| Name: | | | | | Relationship: | | |
| Address: | | | | | | | |
| Phone: | | | | | Email: | | |
| **MEDICAL INFORMATION:** | | | | | | | |
|  | | | | | | | |
| Clinical Diagnosis: | | | | | | | |
| Treating Psychiatrist (Name, address): | | | | | | | |
| Treating Therapist/Counselor (Name, address): | | | | | | | |
| Primary Care Physician (Name, address): | | | | | | | |
| Psychiatrically Hospitalized: Y/N - Yes | If yes, When: | | | | | | |
| Current Medications (names and dosage): | | | | | | | |
|  | | | | | | | |
| Allergies: | | | | | | | |
| \*Is this appointment accident related? Y/N | | | | | | | |
| \*Preferred Language: | | | | | Need Translator: Y/N | | |
| **INSURANCE** | | | | | | | |
|  | | | | | | | |
| **Primary Insurance(company name):** | | | | | | **Subscriber:** | |
| In Network? Y N | | | Fee Due at Time of Service: | | | | |
| **Member ID:** | | | | | | | |
|  | | | | | | | |
| **Secondary Insurance (company name):** | | | | | | **Subscriber:** | |
| In Network: Y N | | |  | | | | |
| **Member ID:** | | | | | | | |
| Additional Information: | | | | | | | |
|  | | | | | | | |

Pregnancy and Postpartum Specific Questions:

## This questionnaire focuses on the reproductive events in your life, such as pregnancy, miscarriages, and adoption. Please fill out the questionnaire with as much detail as you can. If a question does not apply to you, do not complete.

|  |  |  |
| --- | --- | --- |
| Reproductive event | Total number of times this occurred | Year(s) of occurrence |
| Pregnancies that resulted in a live birth |  |  |
| Miscarriages |  |  |
| Elective abortions |  |  |
| Stillbirths or loss of baby between 20-40 weeks gestation. |  |  |

1. Approximately when (date) do you plan to start trying to become pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have you experienced depression or anxiety with prior pregnancies (either while pregnant, after delivery or after termination/loss)?

**YES** **NO Not Applicable**

If YES, please describe the symptoms you experienced\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have any first-degree female blood relatives (mother and/or sisters) suffered from depression or anxiety in pregnancy or the postpartum?

**YES** **NO**

If YES, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **Please check the box to rate your current symptoms** |  | | | |
| Symptom | Not at all | Mild | Moderate | Severe |
| 1. Depressed mood or feelings of hopelessness |  |  |  |  |
| 2. Feelings of elation or agitation associated with symptoms like an exaggerated self-confidence; decreased need for sleep without a loss of energy; a sense that thoughts are racing; or increased activities or plans. |  |  |  |  |
| 3. Improved mood (specifically an *improvement* in the symptoms of your mood disorder) |  |  |  |  |
| 4. Feeling very anxious, more so than what you would consider normal |  |  |  |  |
| 5. Having recurrent, unwanted intrusive ideas/images/impulses that seem silly or horrible |  |  |  |  |
| 6. Feeling the need to check things over and over or repeat actions over and over, in order to prevent bad things from happening |  |  |  |  |
| 7. Having panic attacks. (Panic attacks are sudden unexpected episodes of anxiety often associated with physical symptoms such as rapid heartbeat, feeling faint, lightheaded, trembling, chest tightness, or shortness of breath, lasting approximately 10 minutes) |  |  |  |  |

1. Have your symptoms, as listed above, interfered with:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Mild** | **Moderate** | **Severe** |
| A. Your work efficiency |  |  |  |  |
| B. Your relationships with coworkers |  |  |  |  |
| C. Your relationships with your family |  |  |  |  |
| D. Your social life activities |  |  |  |  |
| E. Your home responsibilities |  |  |  |  |

Thank you! The information above is all that we will need to schedule your appointment. Below is a checklist to help you prepare for your appointment – please ensure that items on this list are received **at least two weeks before your appointment**.

**Please obtain:**

REQUIRED:

□ Typed summary of care letter from your psychiatric provider. The summary of care should include your primary psychiatric diagnoses and medication trials to date (preferably with dates, efficacy, side effects and reasons medication discontinued). Your provider may use this table [(link to medication table form – Word file here](https://www.hopkinsmedicine.org/psychiatry/specialty_areas/moods/patient_information/docs/women/WRMH_Medication_Table_Jul2021.docx)) to summarize medication trials to date. The link to this form can also be found on our website.

□ Signed Release of information ([link to pdf form](https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/_docs/a_2_1_a_providers_authorization.pdf)) to receive your information and send our recommendations to your current psychiatric providers. The link to this form also be found on our website.

PREFERRED (if available, but not required at first appt):

□ Summary of care from any treating therapist/counselor.

\*\*\*\* Failure to return the required items on the above checklist at least two weeks prior to your evaluation appointment may result in our needing to cancel or reschedule. Please sign below indicating that you have read this information and are in agreement with these terms.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy/ No Show Policy**

We’re glad you have chosen us to provide your mental health care. If you miss your appointments, you compromise your care. We want to remind you of our office policies regarding missed appointments.

 A missed appointment is when you do not show up for an appointment, or cancel your appointment without at least 24 hours notice.

 We strive to be timely and prepared for your scheduled appointment and ask that you give us the courtesy of a call when you are unable to keep your appointment. We have outlined our missed appointment policies below.  

**Telehealth and Office Visits**

We require 24 business-hours notice for cancellation of all routine telehealth and office visits, otherwise a $50 missed appointment fee will be charged.

**1st missed follow up appointment**:  We’ll call and offer to reschedule your appointment. You may be charged a missed appointment fee of $50.

**2nd missed follow up appointment**:  You will receive written notification of your missed appointment and will be charged a missed appointment fee of $50.

**3rd missed follow up appointment**:  You will be charged a missed appointment fee of $50. This may also result in a discharge from the practice.

**Late Policy:**

We allow a 15-minute grace period from your appointment start time. However, if you are late your appointment will be cut short to maintain clinic schedule. If you arrive after 15-minutes from the start of your appointment, you may not be seen and will be rescheduled.

**Term of Care:**

Providers at The Johns Hopkins Reproductive Mental Health Center (RMHC) have completed additional training to gain expertise in the management of psychiatric disorders across pregnancy and in the postpartum. To help provide our expertise to more patients, we provide time-limited clinical care while you are pregnant and up to one year postpartum. At one year postpartum, we can provide referrals and help you transition your care to a general psychiatrist, therapist, or primary care doctor (as deemed appropriate). We are also happy to act as consultants to your treating providers (in which case they will be prescribing your medications) during pregnancy and up to one year postpartum.

By signing below you are indicating that you have read and are in agreement with our clinic policies and terms.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_