HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client but reviewed by medical or clinical staff.

Client Name (First, MI, Last)	**Client No.**	**Age**

Have you had any of the following health problems?

	Now	**Past**	**Never**	**What Treatment Received and Date(s)**
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexually Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts/Thoughts				
Other:				
Other:				

Please note family history of any of the above conditions and your relationship to that family member.

Have you had medical hospitalizations or surgical procedures in the last 3 years?
☐ No ☐ Yes If yes, complete information below.

Hospital	City	Date	Reason

☐ None **Allergies/Drug Sensitivities**

☐ Food (specify):

☐ Medicine (specify):

☐ Other (specify):

☐ Not Pertinent **Pregnancy History**

Currently pregnant? If yes, expected delivery date. ☐ No ☐ Yes	Receiving pre-natal healthcare? If yes, indicate provider. ☐ No ☐ Yes
Last Menstrual Period Date	Any significant pregnancy history? If yes, explain. ☐ No ☐ Yes

Last Physical Examination

By Whom	Date	Phone No. (if known)

Have you had any of the following symptoms in the past 60 days? Please check.

☐ Ankle Swelling	☐ Coughing	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulty
☐ Bed-wetting	☐ Cramps	☐ Memory Problems	☐ Pulse Irregularity	☐ Vaginal Discharge
☐ Blood in Stool	☐ Diarrhea	☐ Mole/Wart Changes	☐ Seizures	☐ Vision Changes
☐ Breathing Difficulty	☐ Dizziness	☐ Muscle Weakness	☐ Shakiness	☐ Vomiting
☐ Chest Pain	☐ Falling	☐ Nervousness	☐ Sleep Problems	☐ Other: _____
☐ Confusion	☐ Gait Unsteadiness	☐ Nosebleeds	☐ Sweats (night)	_____
☐Consciousness Loss	☐ Hair Change	☐ Numbness	☐ Tingling in Arms & Legs	
☐ Constipation	☐ Hearing Loss	☐ Panic Attacks	☐ Tremor	

Nutritional Screening (please check)

☐ No Problem	**Eating** ☐ More ☐ Less ☐ Not Fasting	**Drinking** ☐ More ☐ Less ☐ Take Liquids Only	**Appetite** ☐ Increased ☐ Decreased

☐ Nausea ☐ Vomiting ☐ Trouble Chewing or Swallowing

Special Diet	**Other**

Pain Screening

Does pain currently interfere with your activities? If yes, how much does it interfere with these activities (please check)
☐ No ☐ Yes ☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Please indicate the source(s) of the pain.

Substance Use History/Current Use (please check appropriate columns)

Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use
Alcohol/Beer/Wine				Sleep Medication				Cocaine/Crack			
Marijuana				Tranquilizers				Heroin			
Hashish				Hallucinogens				Pain Medication			
Stimulants				Inhalants				Other:			

Caffeine use? If yes, form (coffee, tea, pop, etc.) ☐ No ☐ Yes	How much a week (cups, bottles)?
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) ☐ No ☐ Yes	How much a week (packs, etc.)?

Print Name of Person Completing Questionnaire	Signature of Person Completing Questionnaire	Date

Clinician Reviewer Comments if any

☐ No Referral Needed ☐ Referral Given for Physical Exam/TB or Hepatitis Screening/Pre-natal Care

Provider Signature/Credentials	Date

Current Medications

Prescription Drugs	**Strength** (5 mg, etc)	**Directions** (such as 1 tablet twice a day or as needed)	**Name of the provider and affiliated agency who prescribed the medication**

Over-the-Counter Medications (such as ibuprofen)	**Strength**	**Directions** (such as "take as needed for pain")

Herbs, Vitamins, Minerals, Etc.	**Strength**	**Directions** (such as one tablet per day)