HEALTH HISTORY QUESTIONAIRE

This form should be completed as fully as possible by client but reviewed by medical or clinical staff. Clients should notify staff if they need any assistance in completing form.

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

Has the client had any of the following health problems?

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

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

Has client had medical hospitalizations/surgical procedure in the last 3 years?
□Yes □No If yes, complete information below.

Hospital	City	Date	Reason

Allergies/Drug Sensitivities

□None □Food(specify) □Medicine(specify) □Other(specify)

□Not Applicable **Pregnancy History**(If Applicable)

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

COMPLETE OTHER SIDE ➡

Last Physical Examination

By Whom	Date	Phone No. (if known)

Has the client 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	□Other:_____
□Constipation	□Hearing Loss	□Panic Attacks	□Tremor	_____

□Not Applicable

Immunizations

Immunizations (child or MR/DD only)-Has client had or been immunized for the following diseases? Please Check.

□Chicken Pox	□Diphtheria	□German Measles	□Hepatitis B	□ Measles
□Mumps	□Polio	□Small Pox	□Tetanus	□Other:

Immunizations Within the Past Year

Height/Weight

Height	**If reporting for a child, has height changed in the past year?** □No □Yes If yes, by how much (+or-)?
Weight	**Has client's weight changed in the past year?** □No □Yes If yes, by how much (+or-)?

Nutritional Screening (Please check)

□No Problem	**Eating** □More □Less □No Eating	**Drinking** □More □Less □Takes 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 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 per week** (cups, bottles)?
Tobacco Use? If yes, form (cigarettes, cigars, smokeless, etc.) □No □Yes	**How much per week?** (packs, etc.)?

COMPLETE OTHER SIDE