

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
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Has the client 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				
Sexual 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 client's relationship to that family member.

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Has client had medical hospitalizations/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. <input type="checkbox"/> No <input type="checkbox"/> Yes	Receiving pre-natal healthcare? If yes, indicate provider. <input type="checkbox"/> No <input type="checkbox"/> Yes
Last Menstrual Period Date	Any significant pregnancy history? If yes, explain. <input type="checkbox"/> No <input type="checkbox"/> Yes

Last Physical Examination

By Whom	Date	Phone No. (if known)
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Has client had any of the following symptoms in the past 60 days? Please check.

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

Not Applicable **Immunizations** (required for child or MR/DD only)

Immunizations - Has client had or been immunized for the following diseases? Please check.

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> German Measles	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Measles
<input type="checkbox"/> Mumps	<input type="checkbox"/> Polio	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Other:

Immunizations Within the Past Year

Height/Weight

Height	If reporting for a child, has height changed in the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, by how much (+ or -)?
Weight	Has client's weight changed in the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, by how much (+ or -)?

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Nutritional Screening (please check)			
<input type="checkbox"/> No Problem	Eating <input type="checkbox"/> More <input type="checkbox"/> Less <input type="checkbox"/> Not Eating	Drinking <input type="checkbox"/> More <input type="checkbox"/> Less <input type="checkbox"/> Takes Liquids Only	Appetite <input type="checkbox"/> Increased <input type="checkbox"/> Decreased

<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Trouble Chewing or Swallowing
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Special Diet	Other
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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.) <input type="checkbox"/> No <input type="checkbox"/> Yes	How much a week (cups, bottles)?
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Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes	How much a week (packs, etc.)?
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Print Name of Person Completing this Questionnaire	Signature of Person Completing this Questionnaire	Date
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Clinician Reviewer Comments if any <input type="checkbox"/> Medical Review Needed

Provider Signature/Credentials	Date
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Comments, Recommendations, or Referrals by Medical Reviewer No Referral Needed

Check Referral(s) Needed and Specify Action(s)

Primary Care Physician: _____
 Healthcare Agency: _____
 Specialty Care: _____
 Other (specify): _____

Recommendations shared with client?

No Yes If yes, client's response.

If no, how will recommendations be shared with client?

Medical Reviewer Signature/Credentials (Nurse, PA, NP, MD, DO)	Date
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