Name:_____

Health History Questionnaire **date_____**

Please answer the following questions as fully as possible. All information is confidential. If there is an item you would prefer to discuss in person only, please indicate so.

Referred by: _____

Please describe the main difficulties that are bringing you to see me. (Use separate page if necessary.)

Please list secondary or additional concerns:

Please indicate past problems with a "P" and current problems with a "C."

___Depression
___Anxiety
___Stress
___Learning disability/ADHD
___Anger
___Obsessions/Compulsions (thoughts or actions that repeat themselves)
___Other: (please explain)
___Manic Episodes
___Chronic Illness
___Chronic Pain
___Loneliness/ lack of relationships
___Eating or Weight Problem
___Abuse/Victimization
___Domestic Violence
___Legal Matters
___Grief/Loss
___Trauma
___Marriage/relationship Issues
___Sexuality/sexual issues
___Family Conflict
___Psychosis
___Phobias/fears
___Eliminating a drug/alcohol habit
___Eliminating Another Habit (ie, overspending, gambling, etc)

Please indicate how the problems are affecting the following areas of your life:

	No effect	Little Effect	Moderate Effect	Much Effect	Extreme Effect	Not applicable
Marriage/relationship	1	2	3	4	5	NA
Family	1	2	3	4	5	NA
Job/school performance	1	2	3	4	5	NA
Friendships	1	2	3	4	5	NA
Financial situation	1	2	3	4	5	NA
Physical health	1	2	3	4	5	NA

Please list any mental health or substance abuse treatment you have had; start with most recent.

Dates Provider or Facility name For what problem? First seen Last seen

_____

_____

_____

Name:_____

Have you ever been psychiatrically hospitalized? Yes no

Have you ever made a suicide attempt? Yes no

Have you ever deliberately injured yourself? Yes no

PAST AND CURRENT MEDICAL HISTORY

Do you see a doctor on a regular basis for health maintenance? Yes No

Please name your doctor and provide a phone # or address if possible.

List any medical problems now or in the past that have required treatment by a doctor or other provider (e.g., chiropractor, acupuncturist.) Include surgeries.

_____

_____

_____

List **all** medications you currently take, including frequency and dose. Remember to include over-the-counter medicines, herbal remedies, and supplements. (You may instead elect to bring all your medicine bottles in with you to your first visit.)

Name of medication amount taken with each dose when taken/number of times daily who prescribes?

_____

_____

_____

_____

_____

_____

Have you ever had an **allergic or other bad reaction to medicines**? Please list

_____

Please circle any of the following medications you have ever taken.

For depression, anxiety, sleep, and sometimes pain: Lexapro/escitalopram Luvox/fluvoxamine Paxil/paroxetine Prozac/fluoxetine Zoloft/sertraline Effexor/venlafaxine Remeron/mirtazapine Wellbutrin/bupropion Emsam/segeline Anafranil/clomipramine Desyrel/trazodone Elavil/amitriptyline Pamelor/nortriptyline Sinequan/doxepin Surmontil/trimipramine Tofranil/imipramine Nardil/phenelzine Parnate/tranycypromine Buspar/buspirone Ativan/lorazepam Klonopin/clonazepam Xanax/alprazolam Vistaril/hydroxyzine

Mood stabilizers and anticonvulsants; also sometimes for pain: Lithium/eskalith/lithobid Depakote valproic acid Gabatril Keppra Lamictal/lamotrogine Lyrica/pregabalin Neurontin/gabapentin Tegretol/carbamazepine Trileptal/oxcarbazepine Topamax/topirimate Zonegran/zonisamide

Name:_____

Please circle any of the following medications you have ever taken (continued).

Antipsychotics; also used to stabilize mood, and to augment other meds: Abilify/arapiprazole Clozaril/clozapine Geodon/ziprasidone Haldol Prolixin Risperdal/risperidone Seroquel/quetiapine Stellazine Trilafon Zyprexa/olanzapine

For addictive disorders: Antabuse/disulfiram Buprenorphine Campral/acamprosate Naltrexone

For sleep: Ambien/zolpidem Sonata/zaleplon Lunesta/eszopiclone Rozerem/ramelteon Melatonin triazolam Restoril/temazepam Simply Sleep/diphenhydramine/benadryl (as a sleep aid)

Any other medication that you believe is relevant: _____

Your Reproductive and Sexual History:

Are you currently sexually active with others? Yes No

When sexual, are you active with: Men Women Both

Are you using contraception? Yes No not needed **METHOD**: _____

Do you consider your sex life fulfilling? _____

Do you have any sexual difficulties? Yes no

For women: Date of the start of your last period: _____

Do you have any problems in the premenstrual or menstrual period (either physical or emotional)?_____

How many pregnancies have you had? _____ How many live births? _____

Current symptoms/Review of systems: Please circle any of the following symptoms that are bothering you currently, or have been a recent problem.

Fatigue Fever weight loss Sore throat nasal congestion double vision other visual problems (except glasses) Loss of smell Shortness of breath wheezing cough Abdominal pain nausea/vomiting diarrhea blood in stools Extreme sensitivity to cold or heat tremor excessive thirst Chest pain irregular heart beat Joint pain back pain swollen joints Falls Numbness weakness tingling headache urinary incontinence difficulty urinating pain with urination blood in urine Easy bruisability bleeding swollen lymph glands

Other physical symptoms:

Your Drug, Alcohol & Tobacco History

Have you ever been diagnosed with chemical dependency or alcoholism? Describe when and what treatment you've had.

_____

Name:_____

Average number of cigarettes per day: _____ Ever smoked more? Yes No

Average number of alcoholic drinks per week: _____ Ever drank more? Yes No

List any drugs (not medications prescribed for you) that you have used in the past 10 years (no matter how infrequently):_____

Please circle yes or no for the following questions.

Have you ever felt you should cut down on your drinking or drug use? Yes No

Have friends or family felt you should? Yes No

Do you get annoyed by people's comments about your drinking or drug use? Yes No

Have you ever felt guilty or bad about your drinking or drug use or its effects? Yes No

Have you ever had a drink or used drugs in the morning to help you get going? Yes No

What caffeinated beverages do you drink, and how many per day? _____

Your Home & Environment; safety and legal concerns:

Do you feel safe where you live and work? Yes No

Has anyone hurt, kicked, punched or threatened you recently or in the past? Yes No

Marital status: Single Married Long-term partnership divorced separated

Length of current relationship (if any):

How happy are you with the relationship? Very Somewhat Not very Not at all

Are there any problems with your housing? (risk of eviction, inadequate space, etc) yes no

Please list the members of your household:

Name Relationship Age Health problems

_____

_____

_____

_____

If you have children who are not part of your household, please list their names, ages, and the person they live with:

_____

_____

Do you wear seat belts when you ride in a car? Yes No Sometimes

Do you wear a helmet when cycling? Yes No Sometimes

Are there any weapons kept in your home? Yes No Unsure

If so, are they locked up? Yes No Unsure

Are there any other safety concerns? Yes No

Have you ever assaulted anyone? Yes No

Have you ever had any legal charges against you, or been arrested? Yes No

Have you ever sued anyone, or are you contemplating suing anyone? Yes No

Name:_____

FAMILY HISTORY, GROWING UP, EDUCATION AND EMPLOYMENT

How far did you go in school? _____

If you are working, what is your current job? _____

How long at this job?_____

If not working, when did you last work?_____at what job? _____

When you were growing up, were your parents: together separated divorced ? (circle whichever are appropriate)

Please describe your childhood:

Have you ever suffered abuse (physical, sexual, emotional) in childhood or as an adult? Yes no

Have you experienced any other events that have left a painful impression on you? Yes No Please list:

List any blood relatives who have suffered from the following:

Depression _____

Suicide or suicide attempt _____

Anxiety _____

Nervous Breakdown _____

Obsessions or compulsions _____

Drug or alcohol problem _____

Anger problem or violent behavior_____

Schizophrenia / Psychosis / Hearing Voices _____

Memory loss /dementia before old age _____

Postpartum Depression / Postpartum Exhaustion _____

Possible manic episodes (such as periods of high energy despite little sleep, and unusual behavior)

_____

Other emotional disturbance (describe) _____

Medical diseases that run in your family (e.g., birth defects, cancer, Parkinson's, clotting problems):

_____

If your parents are deceased, age at death and cause of death for each:

_____

_____

Please list anything else about your situation that I should know:

Thank you for completing this. *Reviewed with patient, on _____by E. Alexander, M.D.*