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**

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.

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

Has client had medical hospitalizations/surgical procedures in the last 3 years?

☐ No ☐ Yes If yes, complete information below.

Hospital	City	Date	Reason

Allergies/Drug Sensitivities

☐ None

☐ Food (specify):

☐ Medicine (specify):

☐ Other (specify):

Pregnancy History

☐ Not Pertinent

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)

Has 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	
☐ Constipation	☐ Hearing Loss	☐ Panic Attacks	☐ Tremor	☐ Other: _____
				_____

Immunizations (required for child or MR/DD only)

☐ Not Applicable

Immunizations - 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 -)?

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

Nutritional Screening (please check)

☐ No Problem	**Eating** ☐ More ☐ Less ☐ Not 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? ☐ No ☐ Yes

If yes, how much does it interfere with these activities (please check) ☐ 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? ☐ No ☐ Yes If yes, form (coffee, tea, pop, etc.)	**How much a week** (cups, bottles)**?**
Tobacco use? ☐ No ☐ Yes If yes, form (cigarettes, cigars, smokeless, etc.)	**How much a week** (packs, etc.)**?**

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

Clinician Reviewer Comments if any

☐ Medical Review Needed

Provider Signature/Credentials	**Date**

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**