HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client but reviewed by medical 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

☐ 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
Are you currently breast feeding? ☐ **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	☐ Other:
☐ Constipation	☐ Hearing Loss	☐ Panic Attacks	☐ Tremor	

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

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? 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 this Questionnaire	**Signature of Person Completing this Questionnaire**	**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**