Name: _____

Health History Questionnaire

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.

Please list your main reason for visiting the nurse practitioner today:

_____

_____

Please list secondary or additional concerns you would like to discuss with her:

_____

_____

Your Medical History:

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** and the dates that they occurred.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:

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

_____ _____

Please list ALL medications you have taken to treat psychiatric illnesses, the length of time you took them, and the approximate date you started them. Tell me why you stopped taking them.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you even been hospitalized for a psychiatric illness? Yes No Dates: _____

Where?_____

Have you ever been diagnosed with anxiety or depression? Yes No

If Yes tell me when and who made the

daignosis?_____

_____

Name: _____

Have you ever been diagnosed with bipolar disorder? Yes No

If Yes, tell me when and who made the

diagnosis?_____

_____

Have you even attempted suicide? Yes No Dates: _____

Have you ever had a head injury/lost consciousness from one? Yes No Dates_____

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 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**.) List who prescribes these.**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you ever purchase medications over the internet?_____if yes, which ones?

_____

Your Drug, Alcohol & Tobacco History:

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

_____

Average number of cigarettes per day: _____ Ever smoked more? _____

Average number of alcoholic drinks per week: _____ Ever drank more? _____

Average number of caffeinated drinks per day_____

List any street drugs you use or have experimented with (no matter how infrequently:)

_____

_____

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

Name: _____

Your Reproductive and Sexual History:

What was your age at first menstruation? _____ Are your periods regular? _____

Date of the start of your last period: _____

What problems do you have in the premenstrual or menstrual period (either physical or emotional)?

_____

_____

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

Did you have a surgical birth_____

Any fertility treatment? _____

Have you had any trauma associated with childbirth or pregnancy?_____

_____

Any depression after childbirth?_____Treatment?_____

_____

Any anxiety after childbirth? _____

_____

Approximately how many total months have you breastfed in your life? _____

Approximately how many total months have you used birth control pills or other hormonal contraception (e.g., Depo-Provera, Norplant)? _____

What method of contraception are you using now?

_____

Have you experienced emotional difficulties while on the pill or other hormonal contraception? Y N

Are you now using or have you used hormone replacement therapy for any reason? Y N

Are you currently sexually active with others? Yes No

When sexual, are you active with: Men Women Both

Have you been recently screened for STDs_____

For males: Any problems with erectile dysfunction? _____

Do you consider your sex life fulfilling? _____ Do you have orgasms? _____

Highest weight:_____ Current Weight_____ Height_____

Your Home & Environment:

Who do you live with? _____

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

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

Marital status: Single Married Long-term partnership Other

Length of current relationship: _____

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

Name: _____

Please give the sex, age and health problems of any biological/adopted children:

_____ _____

_____ _____

_____ _____

Do you enjoy parenting? _____

Any concerns about your relationships with your children? _____

_____

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

Your Family Health History:

Are you in contact with your parents?_____

List **any** blood relatives who have suffered from the following:

Depression _____

Suicide _____

Suicide attempt _____

Anxiety _____

Eating Disorder_____

Obsessions or compulsions _____

Drug or alcohol problem _____

Schizophrenia / Psychosis / Hearing Voices _____

Bipolar Disorder_____

Memory loss /dementia before old age _____

Postpartum Depression/Anxiety _____

Psychiatric Hospitalizations_____

Other emotional disturbance (describe) _____

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

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

Mom_____

Dad_____

Sibling_____

Do you consider yourself healthy?_____

Name: _____

How to your promote your own health?_____

Any concerns about your diet or nutrition?_____

Describe any recent or past exposure to trauma (sudden, unanticipated death of a friend or relative, sexual trauma, car accident, death of a child, witness to violence) of any kind:

_____

_____-

_____

Describe recent

stressors_____

_____

_____

What do you do for fun?_____

Do you regularly exercise?_____

How much sleep do you get at night?_____

Medical Review: Please check if you have <u>current</u> symptoms in any of the following areas:

General-

☐ Weight loss or gain ☐ Fatigue

☐ Fever or chills ☐ Weakness

☐ Trouble sleeping ☐ Fever

☐ Hot Flashes

Skin-

☐ Rashes ☐ Lumps ☐ Hives

☐ Itching ☐ Dryness

☐ Color changes ☐ Hair and nail changes

Head-

☐ Headache ☐ Head injury ☐ Neck Pain

Name: _____

Ears-

☐ Decreased hearing ☐ Ringing in ears ☐ Earache ☐ Drainage

Eyes-

☐ Vision Loss/Changes ☐ Glasses or contacts ☐ Pain ☐ Redness ☐ Blurry or double vision ☐ Flashing lights ☐ Specks ☐ Glaucoma ☐ Cataracts ☐ Last eye exam

Nose-

☐ Stuffiness ☐ Discharge ☐ Itching ☐ Hay fever ☐ Nosebleeds ☐ Sinus pain

Throat/Mouth

☐ Bleeding ☐ Dentures ☐ Sore tongue

☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush

☐ Non-healing sores

Neck-

☐ Lumps ☐ Swollen glands

☐ Pain ☐ Stiffness

Breasts-

☐ Lumps ☐ Pain ☐ Discharge ☐ Self-exams ☐ Breast-feeding

Respiratory-

☐ Cough ☐ Sputum ☐ Coughing up blood ☐ Shortness of breath

☐ Wheezing ☐ Painful breathing ☐ Obstructive Sleep Apnea

Cardiovascular-

Name: _____

☐ Chest pain or discomfort ☐ Tightness ☐ Palpitations ☐ Shortness of breath with activity ☐ Difficulty breathing lying down ☐ Swelling ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal-

☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐ Yellow eyes or skin

Urinary-

☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine ☐ Incontinence

☐ Change in urinary strength

Vascular-

☐ Calf pain with walking ☐ Leg cramping

Musculoskeletal-

☐ Muscle or joint pain

☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints ☐

Trauma Neurologic-

☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness ☐ Tingling Tremor ☐ Obstructive Sleep Apnea Do you use a CPAP mask? Yes or no?

Hematologic-

☐ Ease of bruising ☐ Ease of bleeding ☐ Anemia

Name: _____

Endocrine-

☐ Head or cold intolerance ☐ Sweating Frequent urination ☐ Thirst ☐ Change in appetite ☐ weight gain or loss without trying

Psychiatric-

☐ Nervousness ☐ Stress ☐ Depression ☐ Memory loss ☐ Mood instability

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Signed Name Date

Thank you for completing this.