

# Montana City Counseling

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name</b> ( <i>Last, First, M.I.</i> ):	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Current or referring doctor:</b>	<b>Date of last physical exam:</b>	

### PERSONAL HEALTH HISTORY

**Childhood illness:**  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

**List any medical problems that other doctors have diagnosed and state of your general health.**

--	--	--

#### Surgeries

Year	Reason	Hospital

#### Other hospitalizations

Year	Reason	Hospital

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

*Please turn to next page*

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength	Frequency Taken

**Allergies to medications**

Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Sex</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are You HIV Positive? Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Personal Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you consider yourself safe within your current environment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you consider yourself capable of protecting yourself from harm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Have you ever been verbally, physically or sexually abused? Would you like to discuss this issue with your therapist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

**MENTAL HEALTH**

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor/therapist/psychologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please turn to next page

### WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

### MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### OTHER PROBLEMS

Check if you **have, or have had**, any symptoms in the following areas to a **significant degree** and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

*Please turn to next page*

<input type="checkbox"/> Family Crises – home life	<input type="checkbox"/> Abuse	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Trauma	<input type="checkbox"/> Nightmares – Intrusive Thoughts	<input type="checkbox"/> Loss - grief
<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> School - Academic	<input type="checkbox"/> Marital - Relationship
<input type="checkbox"/> Self-Esteem	<input type="checkbox"/> Divorce	<input type="checkbox"/> Frustrated
<input type="checkbox"/> Anxiety/Panic/worry	<input type="checkbox"/> Yelling	<input type="checkbox"/> Concentration – Focus – Decisions- Memory
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Drugs/Alcohol	<input type="checkbox"/> Fearful – Over Anxious
<input type="checkbox"/> Parent/Child	<input type="checkbox"/> Over-Ambitious	<input type="checkbox"/> Aggression – Fighting - Anger
<input type="checkbox"/> Legal Issues	<input type="checkbox"/> Stress	<input type="checkbox"/> Inadequacy - Loneliness
<input type="checkbox"/> Peer Relations	<input type="checkbox"/> Work	<input type="checkbox"/> Financial
<input type="checkbox"/> Unable To Relax	<input type="checkbox"/> Self-inflicted harm	<input type="checkbox"/> Insecurity
<input type="checkbox"/> Dissociation	<input type="checkbox"/> Rape	<input type="checkbox"/> Submissive
<input type="checkbox"/> ACOA –Adult Child of Alcoholics	<input type="checkbox"/> Manic – Over Active – Racing Thoughts	<input type="checkbox"/> Fatigue

The above information is true to the best of my knowledge.

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*