

Panhandle Mental Health Center
 Main Office – 4110 Avenue D, Scottsbluff, NE 69361
 (308) 645-3171

HEALTH HISTORY QUESTIONNAIRE

Date: _____ Family Doctor: _____ Date of Last Physical Exam: _____
 Medication Allergy/Sensitivity? Yes ___ No ___ If yes, please list: _____

Current Medications & Dosages:

Other prescribed and/or non-prescribed medications i.e.:
 antibiotics, used in past 6 months including vitamins &
 herbal preparations:

Circle All That Apply:

HEENT:

1. Headaches
2. Eye problems
3. Glaucoma
4. Double vision
5. Hearing
6. Dental problems
7. Sore tongue
8. Frequent sore throats
9. Nosebleeds
10. Thyroid

RESPIRATORY:

11. Wheezing
12. Trouble breathing

CARDIOVASCULAR:

13. High blood pressure
14. Low blood pressure
15. Dizziness
16. Chest pains
17. Irregular heartbeat
18. Ankle swelling

BLOOD:

19. Easy bleeding
20. Bruise easily
21. Anemia

DIGESTIVE:

22. Difficulty swallowing
23. Stomach pain/ulcer
24. Black stools
25. Constipation
26. Loose stools
27. Nausea
28. Vomiting
29. Diabetes
30. Jaundice
31. Liver

NEUROMUSCULAR:

32. Numbness
33. Epilepsy
34. Loss of consciousness
35. Head injury
36. Shakiness
37. Twitching (involuntary)
38. Abnormal involuntary
muscle movements
39. Arthritis

GENITAL/URINARY:

40. Kidneys
41. Burning on urination
42. Urethral discharge
43. Weak urine stream
44. Prostate problems
45. Lumps in breast
46. Breast discharge
47. Sexual issues

INFECTIOUS DISEASE:

48. Venereal Disease
49. Hepatitis
50. HIV positive
51. AIDS
52. Tuberculosis (TB)

OTHER:

53. Memory
54. Temper
55. Anxiety
56. Hallucinations
57. Ideas that others think are
strange
58. Thoughts that others are
out to get you
59. Depression
60. Suicidal impulses
61. Skin problems
62. Night sweats
63. Lumps
64. Cancer
(type: _____)
65. Genetic disease
66. Other: _____

Have you been diagnosed with
 Hepatitis C? ___ YES ___ NO

Height: _____ ' _____"
 Weight: _____ lbs.
 Hair Color _____
 Eye Color _____

Please complete the following questions:

Are there cultural/religious needs that we need to be aware of? _____

How much coffee, tea, cola do you use daily? _____

How much do you smoke or use tobacco daily? (chew, cigarettes, cigars, pipe) _____

Do you have a history of ineffective chemotherapy? Yes No If yes, please explain: _____

Client Name _____
 Acct # _____

Are your immunizations up to date? Yes No If no, please list what you have not had: _____

Do you have special dietary needs? _____

Have you ever experienced a head injury? (Examples: sports injury, car accident, a fall) _____

Please describe any on-going disabilities & tell us how you cope with the disability: _____

FOR WOMEN ONLY

Number of: Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____ Stillbirths: _____

Method of birth control: _____ Are you pregnant now? _____

Are you breast feeding? _____ Do you have a vaginal discharge? _____

Do you have pain in your breasts? _____ Do you have problems with menstruation? _____

Other female concerns: _____

HOSPITALIZATIONS

Operations/Illnesses	Dates	Locations
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Mark an X in the appropriate box according to your family history:

	Father	Mother	Brother/Sister	Spouse	Children
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain/ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause of death					

Client Name _____
Acct # _____

Client/Patient Signature

Date

Staff Signature

Client Name _____
Acct # _____