Riverbend
PSYCHIATRY

***HEALTH HISTORY QUESTIONNAIRE***

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

Name (First, MI, Last) _____M/F_____ DOB _____

Marital status (*circle one*): **married single divorced separated widowed partner**

**Vitals:**

Height_____ Weight_____

**Allergies:** ***Please list all medication allergies and reactions.***

Name of Medication: _____Reaction:_____
Name of Medication: _____Reaction:_____
Name of Medication: _____Reaction:_____

**Medications:** ***Please list all medications you are currently taking including over the counter drugs.***

Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____

**Psychiatric Medications:** ***Please list all psychiatric medications you have tried in the past.***

Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____
Name of Medication: _____Strength:_____

**Problems:** ***Please list any medical problems that other doctors have diagnosed.***

_____
_____
_____

**Surgical History/ Hospitalizations:**

| Year | Reason | Hospital |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Past Medical History:** Do you have a past history of any of the following?

| | | | |
|---|---|---|---|
| AIDS/HIV | ( ) Yes ( ) No | Headaches | ( ) Yes ( ) No |
| Arthritis | ( ) Yes ( ) No | Hospitalizations | ( ) Yes ( ) No |
| Asthma | ( ) Yes ( ) No | Liver Disease | ( ) Yes ( ) No |
| COPD | ( ) Yes ( ) No | Neurologic | ( ) Yes ( ) No |
| Cancer | ( ) Yes ( ) No | Other | ( ) Yes ( ) No |
| Cardiovascular | ( ) Yes ( ) No | Parkinson's Disease | ( ) Yes ( ) No |
| Diabetes | ( ) Yes ( ) No | Seizures/Epilepsy | ( ) Yes ( ) No |
| ENT | ( ) Yes ( ) No | Stroke | ( ) Yes ( ) No |
| Eye Problems | ( ) Yes ( ) No | Thyroid Disease | ( ) Yes ( ) No |
| Fibromyalgia | ( ) Yes ( ) No | Traumatic Brain Injury | ( ) Yes ( ) No |
| GERD/Reflux | ( ) Yes ( ) No | | |
| Genitourinary | ( ) Yes ( ) No | | |

**Family Mental Health History:** *Has anyone in your family been diagnosed with or treated for:*

| | | | |
|---|---|---|---|
| Bipolar disorder | ( ) Yes ( ) No | Schizophrenia | ( ) Yes ( ) No |
| Depression | ( ) Yes ( ) No | Post-traumatic stress | ( ) Yes ( ) No |
| Anxiety | ( ) Yes ( ) No | Alcohol abuse | ( ) Yes ( ) No |
| Anger | ( ) Yes ( ) No | Other substance abuse | ( ) Yes ( ) No |
| Suicide | ( ) Yes ( ) No | Violence | ( ) Yes ( ) No |

*If yes, who had each problem?*_____

*Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No*

*If yes, who was treated, what medications did they take, and how effective was the treatment?*

_____

**Social History:**

***How was growing up in your home?*** **(Circle one)**

Physical abuse Sexual abuse Emotional abuse Normal Strict

***How many biological brothers do you have?*** _____

***How many biological sisters do you have?*** _____

***What is your birth order?*** (First, Last, etc) _____

***What is your highest education level completed?*** _____

**Type of degree obtained:** HS graduate GED BA/BS Other: _____

***What is your employment status?***

Employed Disabled Student Retired

***Have you served in the Military?*** ( ) Yes ( ) No

***Do you have any legal issues?*** ( ) Yes ( ) No

***Are you religious/spiritual?*** ( ) Yes ( ) No

***What religion do you practice?*** _____

***What is your relationship status? (Circle one)***

Single Married Divorced Separated Widowed Domestic partnership

***Do you live alone or with others?*** _____

***Do you have any children?*** ( ) Yes ( ) No ***How many?*** _____

***Are you sexually active?*** ( ) Yes ( ) No

**Substance Abuse History:**

***Smoking status (Circle one)***

Never Former (Quit date_____) Current every day Current occasional

Packs per day:_____ Years of use:_____

***Do you currently use recreational drugs?*** ( ) Yes ( ) No
***If yes, which ones?*** _____

***Alcohol intake (Circle one)***

None Occasional Moderate Heavy