Original Date: ____/____/____
Dates Revised: ____/____/____
____/____/____
____/____/____

HEALTH HISTORY QUESTIONNAIRE

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

Name: ☐ F

Address::

DOB ____/____/____
SSN ____/____/____
County of Residence: ____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Medical Card ☐ Yes ☐ No

Medical Card Number: _____
Medical Card Copy ☐ Yes ☐ No

Previous or Referring Doctor:

Date of Last Physical Exam:

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates if known:
☐ Tetanus _____ ☐ Pneumonia _____
☐ Hepatitis _____
☐ Influenza _____

List Any Medical Problems That Other Doctors Have Diagnosed:

List any mental health problems, diagnosis and treatments:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ..... ☐ Yes ☐ No

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

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting? ..... ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? e.g. diabetic..... ☐ Yes ☐ No
# of meals you eat in an average day?_____
Have you ever had an Eating
Disorder?_____Treatment:_____
Have you ever abused Laxatives?_____

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day?_____

Alcohol:
Do/did you drink alcohol? ..... ☐ Yes ☐ No
Last drink_____
If yes, what kind?_____ How many drinks per week?_____
Are you concerned about the amount you drink? ..... ☐ Yes ☐ No
Have you considered stopping? ..... ☐ Yes ☐ No
Have you ever experienced blackouts? ..... ☐ Yes ☐ No
Are you prone to "binge" drinking? ..... ☐ Yes ☐ No
Do you drive after drinking? ..... ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ..... ☐ Yes ☐ No
Cigarettes - #/day_____ ☐ Chew - #/day _____
☐ # of Years ☐ or Year Quit_____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:
Did you or are you currently use recreational, prescription or street drugs? ☐ Yes ☐ No
What are your drugs of choice:_____
When was the last time you used each drug? _____
Have you used drugs intravenously? ..... ☐ Yes ☐ No
Have you ever shared needles, equipment, etc?_____
Have you ever been tested for HIV or Hepatitis,
When,Results_____
Would you like to be tested while in treatment?_____
Have any of your sexual partners used IV drugs and /or been since diagnosed with HIV or Hepatitis? _____
Have you had follow-up/treatment for HIV/Hepatitis:

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? ☐ Yes ☐ No

Sex:

Are you sexually active? ☐ Yes ☐ No
If yes, are you trying for a pregnancy? ☐ Yes ☐ No
If not trying for a pregnancy list contraceptives or barrier methods used?

Any discomfort with intercourse? ☐ Yes ☐ No

Do you use condoms with your sexual partners:
Rarely…Occasionally…Routinely…Always

Personal Safety:

Do you live alone? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No
Do you have vision or hearing loss? ☐ Yes ☐ No
Have you ever been physically, sexually or verbally abused by anyone? _____
Have you ever sought counseling for the abuse? _____

Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

Additional problems or concerns:

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Children	Age	Age at Death	Significant Health Problems or Cause of Death
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

MENTAL HEALTH

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Have you ever been to a counselor? ☐ Yes ☐ No
Have you ever been hospitalized for mental health issues? When, Where?_____

WOMEN'S ISSUES

Age at onset of menstruation: _____ Date of last menstruation: ____/____/____
Period every _____ days. Heavy periods, irregularity, spotting, pain or discharge? ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____ Number of Abortions_____ Miscarriages_____
Any complications during pregnancy/delivery_____
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a Tubal Ligation?: Yes…No When_____
Have you had a D&C, hysterectomy or cesarean? ☐ Yes ☐ No
Any urinary tract, bladder or kidney infections within the last year? ☐ Yes ☐ No
Any blood in your urine? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
Any hot flashes or sweating at night? ☐ Yes ☐ No
Do you have menstrual tension, pain, bloating,
irritability or other symptoms at or around time of period? ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps or nipple discharge? ☐ Yes ☐ No
Date of last pap and rectal exam? ____/____/____
Have you been treated for any Sexually Transmitted Disease?_____

OTHER PROBLEMS

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

☐ Skin Rashes_____
Open sores_____
☐ Tatoos_____
☐ Head/Neck _____
Headaches _____
☐ Ears _____
Hx of past infections_____
☐ Eyes _____
Glasses _____
☐ Nose _____

☐ Throat_____
☐ Lungs _____
☐ Chest/Heart _____
Abnormalities_____
☐ Back_____
Injurys_____
☐ Intestinal _____
☐ Bladder _____
☐ Bowel _____
☐ Circulation _____

☐ Changes in Weight _____
Gain/Loss _____
☐ Current Energy Level _____
☐ Ability to Sleep_____
Do you use prescribed or over the counter meds to sleep?_____
Other Pain/Discomfort:
_____
_____
_____

Date:

Signature of RN Reviewer:

TB RISK ASSESSMENT

Client Name: _____

Date of Birth: _____ **Age:** _____

1. Have you had contact with someone who has infectious TB disease? ____ **Yes** ____ **No**
2. Were you born in an area of the world where TB is common (i.e., Asia, Africa, Latin America)? Or have you visited any of these areas for an extended period of time (2 months or longer) ____ **Yes** ____ **No**
   If Yes, where? _____
3. Are you of low-income group with little access to health care, including those who have been homeless in the last two years? ____ **Yes** ____ **No**
4. Have you lived or worked in a residential facility (i.e., nursing homes, correctional facilities, or treatment facilities)? ____ **Yes** ____ **No**
5. Have you worked in a facility where you may have been exposed to TB (health care workers who serve high risk populations)? ____ **Yes** ____ **No**
6. Do you have any of these risk factors for TB? Please check all that apply.

____	Diabetes	____	Tobacco use (current)
____	Kidney failure	____	Alcohol use (current)
____	In jail/prison last 12 months	____	Marijuana use (current)
____	Immunosuppressive therapy (i.e., steroids, chemotherapy)	____	Injection drug use (ever)
____	Crack/cocaine use (ever)	____	No TB risk factors

7. Have you had any TB symptoms in the past six months? Please check all that apply.

____	Cough for more than 2 weeks	____	Night sweats
____	Fever	____	Sputum production or blood with cough
____	Unexplained weight loss	____	Fever, chills, or night sweats for no reason
____	Increased fatigue	____	Chest pains

8. Have you had sexual contact with or shared needles with an HIV/AIDS infected person? ____ **Yes** ____ **No**
9. Have you ever had a test for HIV/AIDS? ____ **Yes** ____ **No**
   If Yes, were the results of this test: ____ **Positive** ____ **Negat.**
10. Have you ever had a TB skin test? ____ **Yes** ____ **No**
    If Yes, were the results of this test: ____ **Positive** ____ **Negat.**
11. Have you ever had a chest x-ray after a TB skin test? ____ **Yes** ____ **No**
    If Yes, when? ____ **Where?** ____ **Results ?**
12. Have you ever taken medications for TB? ____ **Yes** ____ **No**
    If Yes, when? ____ **Where?** ____ **No**

Please sign that you consent for us to give you a Mantoux skin test for the purpose TB screening

_____ _____

Client Signature **Date**

Location of screening: _____

Date TB skin test placed: ____/____/____ **Time:** _____ **Arm:** __right __left

TB skin test given by: _____ **PPD Lot #** _____ **Exp. Date:** _____

Date TB skin test read: ____/____/____ **Time:** _____

TB skin test read by: _____ **TB skin test result** _____

PHYSICAL

Name:	DOB:	Age:	Date:
Height:	Weight:	B/P:	Pulse:
Glasses:	Hearing Loss: R L	Nutrition: Adequate Inadequate	
Chief Complaint/Recent Illnesses:			
Drug of Choice:		Last Use:	IV use? Y N
Immunizations: Hep B: Y N		Flu: Y N	
Last Doctor Visit:		ALLERGIES	

Skin:	WNL			Tattoos:	
Lymph Nodes:	WNL				
Head:	WNL				
Eyes:	WNL				
Ears:	WNL				
Nose & Throat:	WNL				
Teeth & Mouth:	WNL				
Heart:	WNL				
Lungs:	WNL				
Chest:	WNL				
Abdomen:	WNL				
Genitalia:	WNL		Last Pap:	G: Ab:	P: M/C:
Skeletal:	WNL				
Psycho-Social:	WNL	Prior Psych Dx: Depression Anxiety			
Neuromuscular:	WNL				

MD Signature _____