Health History

Name: _____ Date: _____

How would you rate your health?

❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Do you have any medical problems? ❑ No ❑ Yes

If yes, please describe:

Are you currently receiving medical care? ❑ No ❑ Yes

If yes, where:

Do you have a primary care provider? ❑ No ❑ Yes

If yes, provide contact information:

Name _____
Address _____
_____
Phone _____

Do you have a psychiatrist? ❑ No ❑ Yes

If yes, provide contact information:

Name _____
Address _____
_____
Phone _____

Have you had counseling in the past? ❑ No ❑ Yes

If so, when and with whom?

Have you ever been hospitalized in the past (please include psychiatric as well as medical hospitalizations)? ❑ No ❑ Yes

If yes, when?

For what reasons?

Injuries/Surgeries?

Please list all medications you are regularly taking—prescription and non-prescription-- and include psychotropic medications, vitamins and herbal supplements.

Name	Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENERAL HEALTH INFORMATION:

Have you gained weight recently? ❑ No ❑ Yes

If yes, how much weight? _____

Have you lost weight recently? ❑ No ❑ Yes

If yes, how much weight? _____

Do you have any of the following symptoms (check all that apply):

❑ Anxiety
❑ Depression
❑ Headaches
❑ Sleeplessness
❑ Fatigue
❑ Feeling tired after sleeping
❑ Slurred speech
❑ Tremors
❑ Dizziness
❑ Difficulty remembering places or events

Cigarette Use:

- ❑ Never smoked
- ❑ Current smoker
  Amount _____ Year started _____
- ❑ Past smoker
  Year started _____ Year quit _____ Amount _____

Caffeine Use (check all that apply):

- ❑ None
- ❑ Coffee _____ cups/day
- ❑ Tea _____ cups/day
- ❑ Soda _____ oz/day
- ❑ "Power" drinks (e.g. Red Bull) _____ cans/day
- ❑ Tablets (e.g. No Doz) _____ pills/day
- ❑ Liquids (e.g. 5-hour energy) _____ doses/day

Alcohol Use:

- ❑ Never used alcohol
- ❑ Currently use alcohol
  What type (e.g. wine, beer, vodka, etc.) _____
  Estimated amount per week _____

Have you ever felt you should cut down on your drinking?

❑ No ❑ Yes

Have people annoyed you by criticizing your drinking?

❑ No ❑ Yes

Have you ever felt bad or guilty about your drinking?

❑ No ❑ Yes

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

❑ No ❑ Yes

Are you or others concerned about your use of non-prescription or illicit drugs?

❑ No ❑ Yes

My current diet is:

❑ Satisfactory ❑ Unsatisfactory

My current exercise/activity level is:

❑ Satisfactory ❑ Unsatisfactory

Have you used any of the following in an effort to lose weight?

- ❑ Dieting
- ❑ Exercising
- ❑ Medications
- ❑ Supplements
- ❑ Purging (intentional vomiting)

OB/GYN:

Last GYN exam: _____

Gyn concerns? _____

Are you pregnant?

❑ No ❑ Yes

Have you ever had a miscarriage?

❑ No ❑ Yes

If you have any other health concerns, please describe.