Samaritan
Behavioral Health

HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client and reviewed by medical staff.

Client Name (Last, First, MI):	**Age:**	**Gender:** ☐ M ☐ F ☐Other Defined	**Today's Date**

Has the client had any of the following Medical Conditions?

Medical Condition	**Yes**	**No**	**Medical Condition**	**Yes**	**No**
Arthritis &/or Bone/Joint Problems	☐	☐	Oral Health/Dental	☐	☐
Asthma	☐	☐	Stomach/Bowel Problems	☐	☐
Bleeding Disorder	☐	☐	Stroke	☐	☐
Blood Pressure (high or low)	☐	☐	Thyroid	☐	☐
Cancer	☐	☐	Tuberculosis	☐	☐
Cirrhosis/Liver Disease / Hepatitis/ Jaundice	☐	☐	AIDS/HIV	☐	☐
Diabetes	☐	☐	Hepatitis C	☐	☐
Epilepsy/Seizures	☐	☐	Sexual Transmitted Disease	☐	☐
Eye Disease/Blindness/Vision Changes/ Glaucoma	☐	☐	Learning Problems	☐	☐
Fibromyalgia/Muscle Pain	☐	☐	Speech Problems	☐	☐
Headaches	☐	☐	Eating /Nutritional Problems	☐	☐
Head Injury/Brain Tumor	☐	☐	Sexual Problems	☐	☐
Hearing Problems/Deafness	☐	☐	Sleep Problems	☐	☐
Heart Disease	☐	☐	Confusion / Memory Problems	☐	☐
Kidney Disease	☐	☐	Other:	☐	☐
Lung Disease	☐	☐	Other:	☐	☐

Please give details of any of the above checked conditions.

Please note family history of any of the above conditions and client's relationship to that family member.

Health Care Utilization

Name of Primary Care Physician: ☐ None Address/Phone:
Date of Last Physical Exam: ☐ Unknown

Pain Screening: Pain Issues? ☐ No ☐ Yes Does pain interfere with your activities? ☐ No ☐ Yes

If yes, how much does it interfere with these activities (please check) ☐ Not at All ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely

Please indicate the source of the pain.

Height/Weight

Height:	If reporting for a child, has height changed in the past year? ☐ No ☐ Yes - by how much (+ or -)?
Weight:	Has client's or child's weight changed in the past year? ☐ No ☐ Yes - by how much (+ or -)?

Allergies/Drug Sensitivities ☐ No Known Allergies to Medications/Drug ☐ No Known Allergies to Other

☐ Medications/Drugs ☐ Food ☐ Insects ☐ Animals ☐ Materials ☐ Other:

Specify Allergen and Reaction:

Past Medications? ☐ Yes ☐ No
If yes, please list:

☐ None Reported

Current Prescription and Over-the-Counter Medications ☐ No Medications ☐ None Reported

Name of Prescription, over-the-counter medication or herbal therapy	Taken for what condition	Dose/ Route/ Frequency	Side Effects?	Is this medication effective?	Assistance needed in taking or managing your medications?	Prescriber
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	

Use of any complementary health approaches (Acupuncture, Massage, Meditation, Yoga, etc.)? **Yes** **No**
If yes, please describe:

Use of Assistive Devices (cane, walker, wheelchair, hearing aids, etc.)? **Yes** **No**
If yes, please describe:

At Risk behaviors:

☐ None Indicated	☐ Extreme Sports	☐ Taking meds not prescribed to you	☐ Uncontrolled shopping/ spending
☐ Driving at Excessive Speeds	☐ Needle Sharing	☐ Taking more medication than prescribed	☐ Unprotected Sex
☐ Driving under the influence	☐ Self-Cutting Behavior	☐ Uncontrolled gambling	☐ Other

Immunizations - Has client had or been immunized for the following diseases? Check all applicable or ☐ None/Unknown

☐ Adults: Pneumonia	☐ Chicken Pox	☐ German Measles	☐ Measles	☐ Polio
☐ Age 60+: Shingles	☐ Diphtheria	☐ Hepatitis B	☐ Mumps	☐ Tetanus
☐ Age 65+: Prevnar 13	☐ Flu Shot - within last 12 mos.	☐ COVID	☐ Other	☐ Other

Pregnancy History: Total number of births: _____ Currently Pregnant? ☐ No ☐ Yes, expected due date:
If currently pregnant, stage of pregnancy: ☐ Unsure ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester
Receiving pre-natal healthcare? ☐ No ☐ Yes, Provider: _____ Week Prenatal care began:
Child birth within last 5 years? ☐ No ☐ Yes Are you currently breastfeeding? ☐ No ☐ Yes
Any significant pregnancy history? ☐ No ☐ Yes If yes, explain:

Advance Directive / Living Will: Do you have an Advance Directive/Living Will for medical care or psychiatric care? (If you were unable to make decisions for yourself) ☐ No ☐ Yes If yes, provide details:

Payee/Guardianship Do you have a guardian or payee (adults)? ☐ No ☐ Yes If yes, details:

Name of Person Completing form	**Relationship to Client**	**Date**

Office Use Only: Clinician to review Health History with client and enter into electronic health record. Send as next to sign to Nurse. Nurse's signature on Health History in client's electronic health record denotes completion of Medical Review.

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