MODIFY

MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Patient Name: _____ Date of Birth:_____

Please answer the following questions. Your answers are confidential.

1. Please briefly explain the reason for your visit and any symptoms you are experiencing:

_____

_____

_____

2. In the past year have you had a physical exam? Yes _____ No _____

3. Have there been any changes in your general health within the last year? Yes _____ No _____
If Yes, Please specify_____

_____

4. Are you currently under the care of a physician or other mental health professional? Yes_____ No_____
If Yes, Please specify what is the condition being treated? _____

_____

**What is the name of your physician/mental health professional? _____*
**Would you like us to coordinate care with them? Yes_____ No_____ Phone:_____*

5. Have you experienced any serious illnesses, operations, medical or psychiatric hospitalizations?
Yes_____ No_____ If yes, please describe. _____

_____

6. Are you currently taking any non-prescription or prescription medications? Yes_____ No_____
If yes, list name and dosage along with your height _____ and weight_____.

_____

_____

7. Are there any spiritual /cultural factors you would like us to be aware of during your care?
Yes_____ No_____, If yes please specify:_____

_____

MODIFY

8. Please answer "Yes" or "No" to the following as pertains to you, if yes please specify details.

**Allergies*	*Yes_____ No_____*	*Specify:(include drug allergies/reactions)_____*
**Exercise*	*Yes_____ No_____*	*How many times per week? _____*
**Meditation*	*Yes_____ No_____*	*How often?_____ Is it helpful?_____*
**Trouble sleeping*	*Yes_____ No_____*	*Specify:_____*

9. Please answer Yes or No to the following as pertains to you, if yes please specify details.

**Smoke cigarettes*	*Yes_____ No_____*	*How many packs per day/how long?_____*
**Recreational drugs*	*Yes_____ No_____*	*How often?_____ How much?_____*
**Caffeine intake*	*Yes_____ No_____*	*How much per day?_____*
**Alcohol consumption*	*Yes_____ No_____*	*How much per day?_____ per week?_____*
**Gambling*	*Yes_____ No_____*	*How often?_____*
**Legal history*	*Yes_____ No_____*	*Specify:_____*

10. Are you pregnant? Yes_____ No_____ Is your menstrual period late? Yes_____ No_____

11. Do you have or had any of the following diseases or problems? If you answer yes , please specify with dates and detail in the space indicated below.

Seizures/epilepsy	*Yes_____ No_____*	*Head injury*	*Yes_____ No_____*
Anemia	*Yes_____ No_____*	*HIV*	*Yes_____ No_____*
Headaches	*Yes_____ No_____*	*Sleep problems*	*Yes_____ No_____*
Eating Problems	*Yes_____ No_____*	*Heart Problems*	*Yes_____ No_____*
Hyperthyroidism	*Yes_____ No_____*	*Hypertension*	*Yes_____ No_____*
Stroke	*Yes_____ No_____*	*Lung problems*	*Yes_____ No_____*
Sugar/Diabetes	*Yes_____ No_____*	*Hepatitis*	*Yes_____ No_____*
Cancer	*Yes_____ No_____*	*Venereal Disease*	*Yes_____ No_____*
Vision/eye problems	*Yes_____ No_____*	*Kidney Disease*	*Yes_____ No_____*
Dental problems	*Yes_____ No_____*	*Hearing problems*	*Yes_____ No_____*
Late Menstruation	*Yes_____ No_____*	*Other_____*	

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In this section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

1. Alcohol / Substance abuse	____*Yes*	____*No*	_____
2. Anxiety	____*Yes*	____*No*	_____
3. Depression	____*Yes*	____*No*	_____
4. Bipolar Depression	____*Yes*	____*No*	_____
5. Domestic Violence	____*Yes*	____*No*	_____
6. Eating Disorders	____*Yes*	____*No*	_____
7. Obsessive Compulsive Behavior	____*Yes*	____*No*	_____
8. Schizophrenia	____*Yes*	____*No*	_____
9. Suicide Attempts	____*Yes*	____*No*	_____
10. ADHD	____*Yes*	____*No*	_____