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Psychologist

Health History Questionnaire

Name: ______________________________ **Date:** ______________________________
DOB: ______________ **AGE:** ________ **SEX:** ________ **HGT:** ______________ **WT:** ______________
Primary Care Physician: ______________________________ **Phone:** ______________________________
Date Last Seen By Medical Doctor: ______________ **Date of Last Physical Exam:** ______________

Current Medications & Supplements	Dose & Frequency	Prescribing Doctor

FAMILY HISTORY

Relationship (e.g. mother, grandfather)

Emotional Problems	☐ Yes	☐ No	______________________________
Substance Abuse	☐ Yes	☐ No	______________________________
Cardiovascular Disease	☐ Yes	☐ No	______________________________
Kidney Disease	☐ Yes	☐ No	______________________________
Respiratory Disease	☐ Yes	☐ No	______________________________
Cancer	☐ Yes	☐ No	______________________________
Diabetes Mellitus	☐ Yes	☐ No	______________________________
ADD/ADHD	☐ Yes	☐ No	______________________________

PERSONAL HISTORY

Emotional Problems	☐ Yes	☐ No	Substance Abuse	☐ Yes	☐ No
Cardiovascular Disease	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Thyroid-Abnormalities	☐ Yes	☐ No	Neurological Abnormalities	☐ Yes	☐ No
Head Injuries	☐ Yes	☐ No	Seizures	☐ Yes	☐ No

ADD/ADHD ______________________________ **Other:** ______________________________

Previous Counseling (Date and Type): ______________________________
Psychiatrist: ______________________________
Past Surgeries (Date and Type): ______________________________

Do You Smoke: ☐ Yes ☐ No **How much per day?** ________ **How many years?** ________
Do you use alcohol or drugs? ☐ Yes ☐ No **How much per day?** ________
If yes, have you felt the need to cut down? ______________
Type(s): ______________________________