

PERSONAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Medical Record #: _____

Brief description of your problem _____

Current medications including doses _____

Allergies to medications _____

Any medical problems for which you are being treated for _____

Primary care provider _____

Relationship status _____

Children (include ages) _____

Current living situation and household members (i.e., live in apartment with my brother) _____

Receiving Social Security benefits? Yes No

If yes, when did you start receiving benefits? _____

Out-of-state arrests or convictions _____

Currently on probation or parole? If yes, include name of Probation Officer and nature of crime for which you are on probation or parole and number of years/months left on paper

Any past psychiatric hospitalizations (including what hospital, estimated year, and if hospitalization was voluntary or involuntary

Any involuntary psychiatric hospitalizations resulting in a civil commitment of six (6) months or longer?

Suicide attempts (include type of attempt - overdose, cut self, etc.) and approximate dates:

Family history of psychiatric illness or completed suicide (state relationship to you and manner of death):

Employment history:

Employer/Location	Date Started	Date Ended	Reason for Leaving

Longest job _____

Level of education completed (please also note any learning disabilities or special education)

Alcohol or drug treatment:

Date	Location/Clinic	Completed or left early	Length of stay	Length of sobriety after discharge



CHECKLIST: Review of Systems

- General-**
 - Weight loss or gain
 - Fatigue
 - Fever or chills
 - Weakness
 - Trouble sleeping
- Skin-**
 - Rashes
 - Lumps
 - Itching
 - Dryness
 - Color changes
 - Hair and nail changes
- Head-**
 - Headache
 - Head injury
 - Neck Pain
- Ears-**
 - Decreased hearing
 - Ringing in ears
 - Earache
 - Drainage
- Eyes-**
 - Vision Loss/Changes
 - Glasses or contacts
 - Pain
 - Redness
 - Blurry or double vision
 - Flashing lights
 - Specks
 - Glaucoma
 - Cataracts
 - Last eye exam
- Nose-**
 - Stuffiness
 - Discharge
 - Itching
 - Hay fever
 - Nosebleeds
 - Sinus pain
- Throat-**
 - Bleeding
 - Dentures
 - Sore tongue
- Dry mouth
- Sore throat
- Hoarseness
- Thrush
- Non-healing sores
- Neck-**
 - Lumps
 - Swollen glands
 - Pain
 - Stiffness
- Breasts-**
 - Lumps
 - Pain
 - Discharge
 - Self-exams
 - Breast-feeding
- Respiratory-**
 - Cough
 - Sputum
 - Coughing up blood
 - Shortness of breath
 - Wheezing
 - Painful breathing
- Cardiovascular-**
 - Chest pain or discomfort
 - Tightness
 - Palpitations
 - Shortness of breath with activity
 - Difficulty breathing lying down
 - Swelling
 - Sudden awakening from sleep with shortness of breath
- Gastrointestinal-**
 - Swallowing difficulties
 - Heartburn
 - Change in appetite
 - Nausea
 - Change in bowel habits
 - Rectal bleeding
 - Constipation
 - Diarrhea
- Yellow eyes or skin
- Urinary-**
 - Frequency
 - Urgency
 - Burning or pain
 - Blood in urine
 - Incontinence
 - Change in urinary strength
- Vascular-**
 - Calf pain with walking
 - Leg cramping
- Musculoskeletal-**
 - Muscle or joint pain
 - Stiffness
 - Back pain
 - Redness of joints
 - Swelling of joints
 - Trauma
- Neurologic-**
 - Dizziness
 - Fainting
 - Seizures
 - Weakness
 - Numbness
 - Tingling
 - Tremor
- Hematologic-**
 - Ease of bruising
 - Ease of bleeding
- Endocrine-**
 - Head or cold intolerance
 - Sweating
 - Frequent urination
 - Thirst
 - Change in appetite
- Psychiatric-**
 - Nervousness
 - Stress
 - Depression
 - Memory loss