

Behavioral Health & Substance Abuse Network, Inc. (BHSAN)

HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Telephone: (____) _____

Primary Care Physician Name: _____ Telephone : (____) _____

Physician Address: _____

Date of Last Physical Exam _____ What is the reason for your visit to my office? _____

| LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS | | |
|--|----------|-----------------|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |

Relevant medical conditions (history, current condition, changes in condition):

Allergies/adverse reactions to treatment:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | | | |
|----------------|--|---------------------------------------|---------------------------------------|---|-----------------------------|
| Alcohol | Do you drink alcohol? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If yes, what kind? | | | | |
| | How many drinks per week? | | | | |
| | Are you concerned about the amount you drink? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you considered stopping? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you ever experienced blackouts? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Are you prone to "binge" drinking? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you drive after drinking? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tobacco | Do you use tobacco? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | <input type="checkbox"/> Cigarettes – pks./day | <input type="checkbox"/> Chew - #/day | <input type="checkbox"/> Pipe - #/day | <input type="checkbox"/> Cigars - #/day | |
| | <input type="checkbox"/> # of years | <input type="checkbox"/> Or year quit | | | |
| Drugs | Do you currently use recreational or street drugs? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you ever given yourself street drugs with a needle? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

MENTAL HEALTH

| | | |
|---|------------------------------|-----------------------------|
| Is stress a major problem for you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel depressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you panic when stressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have problems with eating or your appetite? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you cry frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever attempted suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble sleeping? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been to a counselor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, when? | | |

Patient Signature

Date