



Patient number: \_\_\_\_\_

## Health History Form

Your answers on this form will help your psychiatrist (psychiatric medical doctor) better understand your medical concerns and conditions. If you cannot remember specific details, please do your best.

**ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL!**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### ALLERGIES:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

#### ALLERGY

#### REACTION

1. \_\_\_\_\_

2. \_\_\_\_\_

### Preferred Pharmacy (Address/ Number):

\_\_\_\_\_

\_\_\_\_\_

### Family Physician and/or Primary Health Care Provider:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_



**May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?**

Yes  No

**Signature:** \_\_\_\_\_

**Past Psychiatric History:**

**Diagnoses:** \_\_\_\_\_

**Medications: (past and present along with doses):**

\_\_\_\_\_

**Suicide attempts:**

Yes  No

**Self-injury:**

Yes  No

**Psychiatric Hospitalizations (where and when):**

\_\_\_\_\_

**Any psychotherapy (in addition to NIALife?):**

Yes  No

**Rehabilitation for substance abuse:**

Yes  No

**Family Psychiatric History:**

Relative	Depression	Bipolar	Schizophrenia	Anxiety
Mom				
Dad				
Maternal Grandmother				
Maternal Grandfather				

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Paternal Grandmother

Paternal Grandfather

Son

Daughter

Aunt

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Uncle

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**Intellectual Disability:**

Yes     No    If yes, whom? \_\_\_\_\_

**Substance Abuse:**

Yes     No    If yes, whom and which substance?

**Any family member complete suicide? (who):** \_\_\_\_\_

**Your Past Medical History (Check all that apply):**

- High blood pressure     High cholesterol     Asthma     Diabetes
- Thyroid Problems     Anemia     Bleeding Disorder     Seizures     Stroke
- Heart Attack     Cancer     Kidney Disease     Liver Disease     Tuberculosis
- HIV/AIDS     Weight loss surgery

**Family Health History (Use above illnesses and list):**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

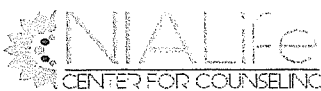
Siblings: \_\_\_\_\_

Children: \_\_\_\_\_

**LIST ALL MEDICATIONS YOU ARE TAKING (BOTH PRESCRIBED AND OVER THE COUNTER):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Has any family member suddenly died at a young age? (who):** \_\_\_\_\_

Yes       No

**Past Surgical History (list all Surgery, reasons, age):**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Substance Abuse History (You, the patient):**

**Alcohol (how many drinks per week):** \_\_\_\_\_

Yes       No

**Tobacco (Cigarettes, cigars, chew per day/week):** \_\_\_\_\_

Yes       No

**Drug use:**

Yes       No      (If yes, list drugs and how often? Last use?)

\_\_\_\_\_

**Additional Health Information:**

**Please add any other information about your health that you would like the doctor to know:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Name (print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Parent Name/Signature (if under 18):** \_\_\_\_\_