

HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions as fully and candidly as possible. Many topics are sensitive and all responses are optional. Your answers are held in strictest confidence as a part of your medical record.

Name:	Age:
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How did you hear of Dr. do Valle?

Marital Status: Single Married Partnered Divorced Widowed

Names and ages of your children, if any:

Please describe your main reason for visiting the doctor today:

Describe any additional concerns you hope to get help with:

Personal Health History

I consider my overall health to be: Excellent Good So-so Poor

Please list any medical problems that other doctors have diagnosed:

List your prescribed drugs and any over-the-counter drugs and supplements:

Drug name	Dose & frequency	Reason you take it

Please list your surgeries:

Year	Type of Surgery & Reason	Results

List any hospitalizations (exclude normal childbirth, mental health or surgery):

Year	Reason for hospitalization	Results or outcome

List any allergic or other adverse reactions to medicines:

Name of drug

Reaction you had

HEALTH HABITS

Number of caffeinated drinks per day:

Any tobacco? Never smoked Smoked but quit I occasionally smoke

Number of alcoholic drinks per week: I abstain from alcohol

If you abstain, is it because drinking has led to problems for you?

Many people with emotional struggles use recreational drugs to cope with their symptoms. Please describe your use of drugs like pot, cocaine, narcotics, speed.

Drug

What you like(d) about this drug

Still using?

Have you ever received treatment for drug use problems? Yes No

If yes, please describe:

Sexual History

I consider myself: Heterosexual Bisexual Lesbian Nonsexual Unsure

Estimate your lifetime number of sexual partners:

Describe any concerns you have about your sexuality (e.g., inability to orgasm, low drive, sex not fulfilling, confused about it in general):

Reproductive History

Are you currently pregnant? Yes, _____ weeks No Trying to conceive

Are you breastfeeding? No Yes, as sole nutrition Yes, part-time Weaning

Date of last menstrual period: _____ I no longer have periods

Are your periods regular? Always Mostly yes Mostly no Not at all N/A

Number of pregnancies: _____

Number of live births: _____

Describe any emotional problems you've experienced while on the pill or implanted contraception, when using progesterone or estrogen, or have premenstrually (PMS):

Please identify your current method of contraception:

Vasectomy Condoms Diaphragm IUD Abstinence Menopause Other

Mental Health History

My childhood was: Happy Unhappy Somewhere in between Traumatic

Please describe any stressful early life events (e.g., parental conflict, death of a loved one, multiple moves/schools, difficulty with friends, aloneness, learning problems, emotional neglect or abuse, physical or sexual abuse)

Mental Health History, cont'd

Please describe any previous experience with counselors or therapists:

Who you saw	For what issue	Length of time

List any medicines you've tried for psychiatric reasons:

Name of drug	Used for what symptoms	Results

What name or diagnosis, if any, have doctors given to your emotional struggles?

Have you ever attempted suicide?

Have you ever needed hospitalization for emotional or psychiatric reasons?

Family & Genetic History

Please indicate symptoms or illnesses suffered by any blood relatives:

Symptom or disorder	Who had/has it	Treated for it?
Depression		
Anxiety		
Obsessions or Compulsions		
Alcohol or drug problem		
Suicide or suicide attempt		
Schizophrenia or other psychosis		
Postpartum depression		
Sensitivity to hormone changes		
Other (please describe)		

Social & Vocational History

Educational background:

High school GED Some college 2 yr degree 4 yr degree or more

If employed outside the home, help me understand your job (title, your main functions and responsibilities)

My job stress is: Nonexistent Manageable Too high Overwhelming

If partnered, how happy are you in the relationship?

Very happy Somewhat happy Somewhat unhappy Not happy at all

I have enough friends and other support in my life: True Not true Unsure

Thank you for completing this.