

Health History Questionnaire

NOTE: This health history is designed to help us gather information so that the staff can work together with you in developing a personalized program. The first step in that process is taking an immediate "inventory" on your health. ALL INFORMATION GIVEN WILL BE KEPT STRICTLY CONFIDENTIAL. Please answer all the questions to the best of your abilities.

HEALTH HISTORY:

When did you last have a physical? _____

What was the physician's name? _____

In what city is your physician's office? _____

What is your Dentist's name? _____

In what city is your Dentist's office? _____

How would you rate your general health at this time? (check one)

_____ Excellent _____ Good _____ Fair _____ Poor

Are you under a doctor's care at this time? _____

If yes, doctor's name: _____

Current medications and dosages: _____

Are you pregnant? _____

Are you overweight? _____ If yes, by how many pounds? _____

Your height: _____ Your weight now: _____ One year ago: _____

Do you have any allergies? _____ If yes, what are they? _____

Please list any medication allergies: _____

Do you smoke or use nicotine? _____

If yes, how much or how many cigarettes per day? _____

Are your veins difficult to draw blood from? _____

List any surgeries you have had: _____

List any hospitalizations you have had:

Other than above, have you ever been seriously ill or injured? _____

If so, please describe: _____

Please check here if you have had or now have any of the following conditions:

- | | |
|-----------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Seizures or Convulsions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Serious Fight/Accident Injury | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Severe Withdrawal Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bowel Trouble | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Prostate Trouble (males) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever/Heart Murmur |
| <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Drug Overdose |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Cesarean Birth (females) |
| <input type="checkbox"/> Abortion/Miscarriage (females) | <input type="checkbox"/> Uterine/Ovarian Problems (females) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Victim of rape, incest/sexual abuse |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Victim of Physical Abuse |
| <input type="checkbox"/> Joint/muscle problem | <input type="checkbox"/> High Blood pressure |
| <input type="checkbox"/> Palpitations or "pounding heart" | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Lung/breathing problems | <input type="checkbox"/> Disease of stomach or intestines |
| <input type="checkbox"/> Problems with "nerves" | <input type="checkbox"/> Ear, nose, throat troubles |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Double vision/blindness | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Sugar in urine |
| <input type="checkbox"/> Glaucoma/cataract | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Frequent or severe headaches |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Hepatitis or liver disease |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Nervous trouble of any kind |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Diseases of skin, hives, eczema etc. |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness or fainting spells |
| <input type="checkbox"/> Allergic to bee stings | <input type="checkbox"/> Poison Oak |
| <input type="checkbox"/> Epilepsy seizure | <input type="checkbox"/> Foot Trouble |
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Back injury or lower back pain |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> "Trick or locked knee" | <input type="checkbox"/> Other health problems |

FAMILY HISTORY:

Please check here if any of your family members have had any of the following conditions and identify who had those conditions (father's mother, mother's mother, father's father, mother's father, father, mother, brother, sister, children, etc.)

- | | |
|------------------------------------------------------------------------|-------|
| <input type="checkbox"/> Alcoholism | _____ |
| <input type="checkbox"/> Bleeding Problems | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Drug Problems | _____ |
| <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Heart Attack | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Hospitalization for mental/emotional problems | _____ |
| <input type="checkbox"/> Mental disorders | _____ |
| <input type="checkbox"/> Psychiatric Treatment | _____ |
| <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Suicide or Attempt | _____ |
| <input type="checkbox"/> Tuberculosis | _____ |

INFECTIOUS DISEASE RISK ASSESSMENT FORM

NAME: _____ DATE: _____

Please fill out the following infectious disease risk assessment form. This form has been approved by the Oregon Health Division and the center for Substance Abuse Treatment. Our Medical Director will review the filled out forms. You may speak with a counselor if you have any questions or want a referral to the local health department or physician for appropriate medical testing.

Circle the answer for each question:

1. Yes No Don't know Have you seen a doctor or other health care provider in the past 3 months?

2. Yes No Don't know Do you live or have you lived on the street or in a shelter?

3. Yes No Don't know Have you ever been in jail/prison/ juvenile detention?

4. Yes No Don't know Have you ever been in a long-term care facility (nursing home/ mental health hospital/hospital)?

5. Where were you born? _____

6. How long have you been in the U.S.? Yrs/months _____

7. Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks:
 Fever
 Drenching night sweats, so bad you had to change your clothes or sheets on the bed
 Productive cough
 Coughing up blood
 Shortness of breath
 Lumps or swollen glands in the neck or armpits
 Losing weight without meaning to
 Diarrhea (runs) lasting more than a week
 Women: Have you missed your last two periods?

8. Yes No Don't know Have you ever been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year?

9. Yes No Don't know Have you ever had a positive skin test for TB? (A test where they gave you a shot in your forearm, and a few days later a hard bump appeared

10. Yes No Don't know Have you ever been treated for TB?

- | | | | | |
|-----|-----|----|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 11. | Yes | No | Don't know | Do you use needles to shoot drugs? |
| 12. | Yes | No | Don't know | Have you shared needles or syringes to inject drugs? |
| 13. | Yes | No | Don't know | Do you use stimulants (cocaine or amphetamines)? |
| 14. | Yes | No | Don't know | In the last 6 months, have you or anybody you have had sex with had any sexually transmitted diseases (STDs), like syphilis, gonorrhea, herpes, Chlamydia, nongonoccal urethritis? |

Everyone is worried about AIDS. Some people are at a higher risk for contracting the AIDS virus, and should make lifestyle changes to prevent infection of themselves or others. However, many people are not at risk of AIDS. To help find out if you are at risk for HIV, the virus known to cause AIDS, please take a minute to answer the following questions.

- | | | | | |
|-----|-----|----|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15. | Yes | No | Don't know | Between 1978 and June of 1985 did you receive more than 5 blood transfusions? |
| 16. | Yes | No | Don't know | Have you had unprotected sex with someone who has the blood disease hemophilia? |
| 17. | Yes | No | Don't know | Have you had unprotected sex with someone injects drugs? |
| 18. | Yes | No | Don't know | Have you had unprotected sex with a man who has sex with other men? |
| 19. | Yes | No | Don't know | Have you had sex in exchange for money or drugs, or in order to survive? |
| 20. | Yes | No | Don't know | Have you had sex with more than one person in the past 6 months? Any type or vaginal, rectal, or oral contact without protection (condom or other barrier) with or without your consent? |
| 21. | Yes | No | Don't know | Have you had sex <u>or</u> shared needles to inject drugs with a person who has AIDS <u>or</u> who tested positive on the antibody test for AIDS/HIV disease? |

If you answered "no" to all the questions, you are not at increased risk for AIDS.
 If you answered, "yes" or "don't know" to any question you may be at risk for AIDS.

The following questions are asked to help with treatment planning. It is not required that you answer them to participate in assessment and/or treatment.

1. Have you ever had a blood test for HIV antibody?
If “no”, would you like a blood test?
2. If yes, have you been tested within the last six months?
3. How would you judge you own risk for being infected with HIV (the AIDS virus)?

I know I am infected _____
I think I am at high-risk _____
I think I am at low risk _____
I think I am at No risk. _____
I am not sure what my risk is _____

Client’s Signature

Date

Client’s Parents/Guardian Signature

Date