



**Pacific
Neuropsychiatric
Specialists**

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	
Family Physician				
Previous or referring doctor:				
Date and Place of last Hospitalization:				
Reason for hospitalization:				
Past Psychiatric History (<i>past psychiatrist, therapist and psychiatric hospitalization</i>):				

Do you:	Yes	No	Name	How Long	Last used
Drink					
Smoke					
Use substance					

List any current medications:

Medications	Dosage	Frequency	Prescribe By	How Long: (years/months)

Family Psychiatric History:

Illness	Mother	Father	Sister	Brother	Other
Psychosis					

Depression					
Bipolarism					
Anxiety					
Schizophrenia					
Hyperactivity					
Inattention					
Obsession					
Compulsion					
Delirium					
Eating Disorder					
Post-partum					
Dementia					
Other					

Family Medical History:

Illness	Mother	Father	Sister	Brother	Other
Psychiatric					
Neurological					
Cardio-vascular					
Endocrinological					
Gastrointestinal					
ENT					
Surgical					
Respiratory					
Other					

Patient Medical History:

Have you had or do you presently have problems with any of the following?

Symptoms	Yes	No	Comments
AIDS/IMMUNE Deficiencies			
Anemia			
Asthma			
Bloody stools/urine			
Bronchitis			
Cancer or Tumors			
Chest pain			
Chronic constipation			
Chronic cough			