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ATLANTA PRIVATE PSYCHIATRY

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I.)	Date of Birth mm/dd/yy	Social Security Number

Allergies To Medication

Name of Primary Care Physician	Telephone Number ( )	Approx. Date of Last Exam.

CURRENT PRESCRIPTION MEDICATIONS

Medication	Dose	Frequency	Medication	Dose	Frequency	Medication	Dose	Frequency

HOSPITALIZATIONS

Date	Hospital	City/State	Reason

LIST ACTIVE MEDICAL PROBLEMS

Do You Use Tobacco?	Do You Drink Alcohol?	Do You Use Recreational Drugs?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No

MEDICAL HISTORY: (CHECK ALL THAT APPLY AND GIVE BRIEF EXPLANATION ON BACK)

☐ High Blood Pressure	☐ Diabetes	☐ High Cholesterol
☐ Cancer	☐ Broken Bones	☐ Thyroid Disease
☐ Surgery	☐ Stroke	☐ Asthma
☐ Emphysema	☐ Hysterectomy	☐ Ovaries Removed
☐ Heart Disease	☐ Ulcer or Gastritis	☐ Diarrhea
☐ Constipation	☐ Hemorrhoids	☐ Blood In Stool

PLEASE CONTINUE ON NEXT PAGE

MEDICAL HISTORY PAGE 2

☐ Liver Disease	☐ Anemia	☐ Urinary Tract Infections
☐ Kidney Disease	☐ Gallbladder Disease	☐ Jaundice
☐ Sexually Transmitted Disease	☐ Night Sweats	☐ Fever
☐ Frequent or Severe Headaches	☐ Seizure (Convulsion)	☐ Loss of Consciousness
☐ Fainting	☐ Dizziness / Vertigo	☐ Visual Problems
☐ Hearing Problems	☐ Swallowing Difficulty	☐ Arthritis
☐ Back Pain	☐ Sinus Trouble	☐ Seasonal Allergies
☐ Skin Disease	☐ Chest Pain	☐ Shortness of Breath
☐ Palpitations	☐ Indigestion	☐ Weakness
☐ Heat Intolerance	☐ Change In Hair / Skin / Nail Texture	☐ Cold Intolerance
☐ HIV / AIDS	☐ History of Intravenous Drug Abuse	☐ Glaucoma
☐ Bleeding Tendency	☐ Head Injury	☐ Numbness
☐ Chest X-Ray	☐ CT Scan or MRI	☐ EKG (Electrocardiogram)
☐ EEG (“Brain Waves”)	☐ Psychological Testing	☐ Other (Details On back)

PSYCHIATRIC HISTORY

Have You Had Therapy or Counseling? ☐ Yes ☐ No	Have You Seen A Psychiatrist? ☐ Yes ☐ No
Have You Been Psychiatrically Hospitalized? ☐ Yes ☐ No	Have You Attempted Suicide? ☐ Yes ☐ No
Have You Taken Medication? ☐ Yes ☐ No	What Is Your Diagnosis? _____
Have You been Treated For Alcoholism? ☐ Yes ☐ No	Have You Been Treated For Drug addiction? ☐ Yes ☐ No
Family Member With Alcoholism? ☐ Yes ☐ No	Family Member With Addiction? ☐ Yes ☐ No

WOMEN ONLY

Age At First Period _____	Date of Last Period _____	Periods Regular ☐ Yes ☐ No
Abnormal Bleeding ☐ Yes ☐ No	Endometriosis ☐ Yes ☐ No	“PMS” ☐ Yes ☐ No
Ovarian Cysts ☐ Yes ☐ No	Abnormal Pap ☐ Yes ☐ No	Sex Satisfactory ☐ Yes ☐ No
Number of Pregnancies _____	Number of Living Children _____	Contraception _____

MEN ONLY

Prostate Problems ☐ Yes ☐ No	Testicular Pain / Swelling ☐ Yes ☐ No	Hernia ☐ Yes ☐ No
Sterility ☐ Yes ☐ No	Erectile Dysfunction ☐ Yes ☐ No	Sex Satisfactory ☐ Yes ☐ No

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