(PLEASE NOTE WE SEE A WIDE VARIETY OF CLIENTS. PLEASE JUST FILL OUT WHAT WORKS FOR YOU, FEEL FREE TO SKIP THE REST.)

| |
|---|
| **Original Date:** |
| Dates **Revised:** |

# HEALTH HISTORY QUESTIONNAIRE

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

| | |
|---|---|
| **Name** *(Last, First, M.I.):* | **DOB:** |
| **Previous or referring doctor:** | **Date of last physical exam:** |

## PERSONAL HEALTH HISTORY

| | | |
|---|---|---|
| **Childhood illness:** | □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio □ HPV | |
| **Immunizations and dates (if known):** | □ Tetanus | □ Pneumonia |
| | □ Hepatitis | □ Chickenpox |
| | □ Influenza | □ MMR *Measles, Mumps, Rubella* |
| | □ HPV | □ Other_____ |

**List any medical problems that other doctors have diagnosed**

**Describe any early childhood developmental delays or concerns you have experienced**

Did you mother consume drugs or alcohol during your pregnancy with you? Yes No

Were there any complications with your labor/delivery? No Yes If yes, describe:

Did you grow and develop normally and on time?

Did you (do you) require extra assistance to meet your academic/occupational needs?

Have you had (or do you have) an IEP or 504 Plan? Yes No

School Attending (if applicable):_____ Grade: (if applicable) _____

If you are done with school do you have a (circle one): Diploma GED Bachelors Degree Graduate Degree

**List any previously tried psychotropic medication (if applicable) and response**

| | | |
|---|---|---|
| | **Hospitalizations (including psychiatric residential stays/substance abuse treatment programs/ongoing outpatient psychiatric/mental health treatment)** | |
| Year | Reason | Hospital/Provider |
| | | |
| | | |
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| **Have you ever had a blood transfusion?** | □ Yes | □No |

| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | |
|---|---|---|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Allergies to medications** | | |
| Name the Drug | Reaction You Had | |
| | | |
| | | |
| | | |

## HEALTH HABITS AND PERSONAL SAFETY

| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. | | | | | | |
|---|---|---|---|---|---|---|
| **Exercise** | □ Sedentary (No exercise) | | | | | |
| | □ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | |
| | □ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | |
| | □ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | |
| **Diet** | Are you dieting? | | | | Yes | No |
| | If yes, are you on a physician prescribed medical diet? | | | | Yes | No |
| | # of meals you eat in an average day? | | | | | |
| | Rank salt intake | □ Hi | □ Med | □ Low | | |
| | Rank fat intake | □ Hi | □ Med | □ Low | | |
| **Caffeine** | □ None | □ Coffee | □ Tea | □ Cola | | |
| | # of cups/cans per day? | | | | | |
| **Alcohol** | Do you drink alcohol? | | | | Yes | No |
| | If yes, what kind? | | | | | |
| | How many drinks per week? | | | | | |
| | Are you concerned about the amount you drink? | | | | Yes | No |

| | | | | |
|---|---|---|---|---|
| | Have you considered stopping? | | Yes | No |
| | Have you ever experienced blackouts? | | Yes | No |
| | Are you prone to "binge" drinking? | | Yes | No |
| | Do you drive after drinking? | | Yes | No |
| **Tobacco** | Do you use tobacco? | | Yes | No |
| | □ Cigarettes – pks./day | □ Chew - #/day | □ Pipe - #/day | □ Cigars - #/day |
| | □ # of years | □ Or year quit | | |
| **Drugs** | Do you currently use recreational or street drugs? | | Yes | No |
| | Have you ever given yourself street drugs with a needle? | | Yes | No |
| **Sexual/ Reproductive Health (Optional)** | Are you sexually active? | | Yes | No |
| | Does your sexual partner have (circle one) penises? vaginas? both? | | | |
| | What word describes your relationship status (single, monogamous, consenually nonmonogamous, polyamorous or other) | | | |
| | Are you attempting to become pregnant or cause a pregnancy? | | Yes | No |
| | Do you wish to discuss fertility concerns today? | | Yes | No |
| | Do you need information on contraception today? | | Yes | No |
| | If not trying for a pregnancy list contraceptive or barrier method used: | | | |
| | Any discomfort with intercourse? | | Yes | No |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | | Yes | No |
| | When was your last testing for sexually transmitted infections? _____ | | | No |
| | Do you know your HIV status? | | Yes | No |
| | Are you interested in HIV testing or discussion around HIV prevention (including PrEP) today? | | Yes | No |
| | Do you have other questions about your sexual or reproductive health? | | Yes | No |
| | Do you wish to discuss safer sex or safe sex exploration with your provider today? | | Yes | No |
| **Gender Health (Optional)** | Do you currently use a hormone product to affirm your gender identity? | | Yes | No |
| | Do you desire information about hormones to affirm your gender? | | Yes | No |
| | Have you ever felt that your assigned gender at birth does not align with your body? | | Yes | No |
| | If you answered yes to the above, please answer: | | | |
| | At what age do you first remember experiencing this? _____ | | | |
| | Have you began the process of either a social, legal or medical transition? Circle all that apply | | Yes | No |
| | Do you use items such as a gaffe, binder, ace wraps or duck tape to align your body contour with your gender identity? | | Yes | No |
| | Would you like to discuss a social, legal or medical transition with your provider today? Circle all that apply | | Yes | No |
| | For patients under the age of 16, are you interested in discussing hormone blocking or pubertal suppression today? | | Yes | No |
| **Personal Safety** | Do you live alone? | | Yes | No |
| | Do you have frequent falls? | | Yes | No |
| | Do you have vision or hearing loss? | | Yes | No |
| | Do you have firearms in your home? | | Yes | No |
| | Do you have an Advance Directive or Living Will? | | Yes | No |
| | Would you like information on the preparation of these? | | Yes | No |
| | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | Yes | No |

## FAMILY HEALTH HISTORY

| | Age | Significant Health Problems | | Age | Significant Health Problems |
|---|---|---|---|---|---|
| **Father** | | | **Children** | □ M □ F | |
| **Mother** | | | | □ M □ F | |
| **Sibling** | □ M □ F | | | □ M □ F | |
| | □ M □ F | | | □ M □ F | |
| | □ M □ F | | **Grandmother** *Maternal* | | |
| | □ M □ F | | **Grandfather** *Maternal* | | |
| | □ M □ F | | **Grandmother** *Paternal* | | |
| | □ M □ F | | **Grandfather** *Paternal* | | |

## MENTAL HEALTH

| | | |
|---|---|---|
| Is stress a major problem for you? | Yes | No |
| Do you feel depressed? | Yes | No |
| Do you feel anxious? | Yes | No |
| Do you panic when stressed? | Yes | No |
| Do you have problems with eating or your appetite? | Yes | No |
| Do you cry frequently? | Yes | No |
| Have you ever attempted suicide? | Yes | No |
| Have you ever seriously thought about hurting yourself? | Yes | No |
| Do you have trouble communicating/getting along with peers, family, friends or coworkers? | Yes | No |
| Do you have trouble sleeping? | Yes | No |
| Do you have safety concerns involving yourself, your family, your community, workplace or friends? | Yes | No |
| Have you ever struggled with substance misuse, abuse, or dependence? | Yes | No |
| Have you ever been to a counselor? | Yes | No |
| Do you have worries or concerns about your body size or shape, or weight gain or loss? | Yes | No |
| Do you have worries or concerns about your eating/exercise patterns? | Yes | No |
| Have you ever had a head injury? | Yes | No |
| Have you ever had a seizure? | Yes | No |
| Have you ever had imaging of your brain? | Yes | No |
| Have you ever experienced a manic episode (your provider will inquire further)? | Yes | No |
| Have you ever experienced a psychotic episode (your provider will inquire further)? | Yes | No |

## People with Vaginas/Estrogen Dominant Bodies (or answer what applies to your body)

| | | |
|---|---|---|
| Age at onset of menstruation: | | |
| Date of last menstruation: | | |
| Period every _____ days | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | □ Yes | □ No |

| | | |
|---|---|---|
| Number of pregnancies _____ Number of live births _____ | | |
| Are you pregnant or breastfeeding? | □ Yes | □ No |
| Have you had a D&C, hysterectomy, or Cesarean? | □ Yes | □ No |
| Any urinary tract, bladder, or kidney infections within the last year? | □ Yes | □ No |
| Any blood in your urine? | □ Yes | □ No |
| Any problems with control of urination? | □ Yes | □ No |
| Any hot flashes or sweating at night? | □ Yes | □ No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | □ Yes | □ No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | □ Yes | □ No |
| Date of last pap and rectal exam? | | |

**PEOPLE WITH PENISES/TESTOSTERONE DOMINANT BODIES (OR ANSWER WHAT APPLIES TO YOUR BODY)**

| | | |
|---|---|---|
| Do you usually get up to urinate during the night? | □ Yes | □ No |
| If yes, # of times _____ | | |
| Do you feel pain or burning with urination? | □ Yes | □ No |
| Any blood in your urine? | □ Yes | □ No |
| Do you feel burning discharge from penis? | □ Yes | □ No |
| Has the force of your urination decreased? | □ Yes | □ No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | □ Yes | □ No |
| Do you have any problems emptying your bladder completely? | □ Yes | □ No |
| Any difficulty with erection or ejaculation? | □ Yes | □ No |
| Any testicle pain or swelling? | □ Yes | □ No |
| Date of last prostate and rectal exam? | □ Yes | □ No |