Caldwell UNC Health Care
Jonas Hill Outpatient Clinic
407 Mulberry Street SW
Lenoir, NC 28645
Office: 828-394-6720 | Fax: 828-3946721

PATIENT HISTORY QUESTIONNAIRE

Date: _____

Patient Name: _____ Date of Birth: _____

What is the reason for your visit?

□ Addiction	□ Confusion	□ Helpless	□ Medication Effects	□ Phobia
□ ADHD	□ Depression	□ Hopeless	□ Memory problem	□ Self-injury
□ Anger/Temper	□ Energy level decreased	□ Impulsivity	□ Obsession/ OCD	□ Schizophrenia
□ Anxiety	□ Grief	□ Irritability	□ Panic Attacks	□ Tearfulness
□ Bipolar	□ Guilt	□ Isolation	□ Paranoia	□ Worthlessness
□ Binge Eating	□ Hallucinations	□ Mania	□ Parkinson's	□ Concentration

PSYCHIATRIC HISTORY

Have you ever been treated for mental health/psychiatric conditions? □ YES □ NO
If YES, then answer the Inpatient and/or Outpatient Treatment History tables below. If NO, then skip

INPATIENT Psychiatric TREATMENT HISTORY IN HOSPITAL or PARTIAL HOSPITALIZATION:

Facility Name	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		
Name: City, State Phone ( ) - Fax ( ) -		

OUTPATIENT Psychiatric / Mental Health / Psychotherapy TREATMENT HISTORY:

Psychiatrist / Therapist / Other Mental Health	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		□ Medication Management □ Psychological Testing □ Therapy(Individual Family Group) □ Additional Explanation:
Name: City, State Phone ( ) - Fax ( ) -		□ Medication Management □ Psychological Testing □ Therapy(Individual Family Group) □ Additional Explanation:

PAST PSYCHIATRIC ONLY MEDICATIONS YOU HAVE TRIED AND ARE NO LONGER TAKING:

Past Psychiatric Medications you have tried	Dose	Frequency	Reason for Stopping
		___x day or |□ AM □ PM □ As needed	
		___x day or |□ AM □ PM □ As needed	
		___x day or |□ AM □ PM □ As needed	
		___x day or |□ AM □ PM □ As needed	
		___x day or |□ AM □ PM □ As needed	

CURRENT MEDICATIONS, ALTERNATIVE MEDICATIONS, HERBS, OVER THE COUNTER, ETC.

Current Medications	Dose (mg, ml, etc.)	Frequency
		___x day or |□ AM □ PM □ As needed
		___x day or |□ AM □ PM □ As needed
		___x day or |□ AM □ PM □ As needed
		___x day or |□ AM □ PM □ As needed
		___x day or |□ AM □ PM □ As needed

Allergies to Medications:	Types of Reaction:

SUBSTANCE ABUSE:

Substance	Have you ever tried before?	Age Started	Last used	Frequency of use	Lost Control?	Comments
Cocaine	□ Yes □ No					
Hallucinogens (LCD, mushrooms, Mescaline)	□ Yes □ No					
Heroin	□ Yes □ No					
IV Drug use	□ Yes □ No					
Marijuana	□ Yes □ No					
Pain Pills	□ Yes □ No					
Other:	□ Yes □ No					

Have you ever been treated for alcohol or drug use and/or abuse? □ YES □ NO

If YES, then complete the Treatment History table below.

Facility Name	Dates of Treatment	Reason or Explanation of this treatment
Name: City, State Phone ( ) - Fax ( ) -		
Name: City, State Phone ( ) - Fax ( ) -		

INPATIENT and/or OUTPATIENT SUBSTANCE ABUSE TREATMENT HISTORY:

SMOKING/TOBACCO USE STATUS: □ Current every day smoker □ Former smoker □ Never smoker

Tobacco Use Pattern

1. How old were you when you became a daily smoker? _____
2. How many years have you used tobacco regularly? _____
3. What form of tobacco do you currently use (i.e. cigarettes, cigar, pipe, chew)? _
4. How many cigarettes do you smoke each day? _____

NUTRITIONAL ASSESSMENT: Height:_____ Current Weight:_____

Without trying, have you lost/gained more than 10 pounds within the last 6 months?___
If YES, Amount Weight Lost_____ Amount Weight Gained:_____

SLEEP PATTERNS: Hours each night: _____
□ Awakens frequently □ Difficulty returning to sleep □ Difficulty falling asleep

FUNCTIONAL ASSESSMENT:

Have you experienced a recent loss of independence in caring for yourself? □ YES □ No
If YES, please explain:
_____
_____
___

FAMILY HISTORY: Has anyone in your family ever been treated for any of the following? Put 'X' where appropriate

Illness	Father	Mother	Brother	Sister	Children	Aunt		Uncle		Grandparent	
						Father's side	Mother's side	Father's side	Mother's side	Father's side	Mother's side
ADHD											
Alzheimer's Disease											
Anxiety / Panic Attacks											
Bipolar Disorder											

Depression											
Heart Disease											
Schizophrenia											
Seizures											
Stroke											
Substance Abuse											
Suicide Attempts											

Past Medical History (have you ever had):

Illness	Yes	No
Cancer		
Arthritis		
Asthma		
Cholesterol Problems		
Depression		
Diabetes		
Diverticulitis/Colitis		
Ear Problems		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Liver Disease		
Lung Problems		
Stroke		
Stomach Problems		
Thyroid Problems		
Tuberculosis		
Other Serious Medical Conditions		

If answered yes to any questions above, please explain: _____

_____

Past Surgical History (any major operations, where and when):_____

_____

_____

Preventive

Illness	Yes	No	Year
Colonoscopy			
Dental Exam			
Eye Exam			
Flu Shot			

Mammogram			
Pap Smear			
Pneumonia Shot			
Prostate Exam			
Tetanus Shot			

_____ _____

Patient Signature Date