PATIENT’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE / /

HISTORY QUESTIONAIRE

 (PLEASE WRITE ON THE BACK IF ADDITIONAL SPACE IS NEEDED)

How did you hear about us or did someone refer you? If referred by whom?

What is your principle complaint?

What other complaints do you have?

How long have you had the problem?

Who is accompanying you on the visit?

Have you seen a therapist or psychiatrist or received previous treatment for this problem?

By Whom?

When were you treated?

What was your diagnosis?

What were the results of your treatment?

Were you prescribed any medicine?

If so please give the name and dosage of the medication and approximately how you took the medication:

Did the medication help?

Did you have problems with the medication and if so what?

Please list any current medications including over-the-counter medicines and how you are taking the medications:

#1

#2

#3

Are you allergic to any medication? If so please name the medication and describe your reaction.

Have you had a bad or adverse reaction to any medication? If so please name the medication and describe your reaction.

Do you have Allergies?

Do you have Asthma?

Do you have or have you had any significant Medical problems e.g. ulcers, high blood pressure etc?

#1

#2

Have you had any operations or surgeries? If so what?

#1

#2

Are there any medical conditions that seem more frequent in your family? What?

Were there any major problems with your mother’s pregnancy or delivery? What

Did you remain in the hospital longer than expected after delivery for medical reasons?

 As an infant did you have colic or spit-up much? How long was it a problem?

How old were you when you began walking?

When you started school did the teachers make any comments about you? If so what?

What was highest grade completed in school?

What were your typical grades?

Grades 1-6 A B C <C

Grades 7-9 A B C <C

Grades 10-12 A B C <C

College A B C <C or GPA \_\_\_\_\_\_

Did you repeat any grades? If so which grades?

Do you get overly nervous when taking a test?

Do you sometimes “blank out” on test?

Do you have any phobias or fears e.g. fear of heights, fear of closed-in places, fear of the dark, fear of being alone, etc? Which fears or phobias?

Does your stomach bother you? How?

Do you frequently have bloating or abdomen or feel as if you have overeaten when you haven’t overeaten?

Do you like milk?

Does milk cause any problems?

What is your favorite flavor of ice cream?

What is your favorite soft drink?

Do you drink coffee or tea? If so are you able to drink a lot without problems?

How does caffeine affect you?

Have you ever taken a diet pill or stimulant, please give the name and dosage (if known) and your reaction e.g. Phentermine 30 mgs.

If you where to eat a large amount of sugar, would you notice any difference in how you feel? What?

Do you smoke? How much?

Regarding sleep:

Are you a night person?

Once you lie down to go to sleep does it take you long to get to sleep? How long?

Once you are asleep are you a sound sleeper e.g. sleeps through storms?

 Are you hard to awaken or to get up or to get going in the morning?

Do you have nightmares or “weird” or bad dreams?

Was bedwetting ever a problem?