VR Behavioral Health Services

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Patient Health History

Patient Name_____ Date_____ DOB_____

Date of last physical exam_____ Reason for visit? _____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYE/EAR/NOSE/THROAT	CARDIOVASCULAR
□ Chills	□ Poor Appetite	□ Bleeding gums	□ Chest pain
□ Depression	□ Bloating	□ Blurred vision	□ High blood pressure
□ Dizziness	□ Bowel changes	□ Visions – Halos or Flashes	□ Irregular heart beat
□ Fainting	□ Constipation	□ Difficulty swallowing	□ Low blood pressure
□ Fever	□ Diarrhea	□ Double vision	□ Poor circulation
□ Forgetfulness	□ Excessive hunger	□ Earache	□ Rapid heart beat
□ Headache	□ Excessive thirst	□ Sinus problems	□ Varicose veins
□ Loss of sleep	□ Stomach pain	□ Hay fever	
□ Loss of weight	□ Vomiting blood	□ Ringing in ears	
□ Nervousness	□ Indigestion	□ Loss of hearing	
□ Numbness	□ Nausea	□ Nosebleeds	
□ Sweats	□ Vomiting	□ Persistent cough	

CONDITIONS Check (√) conditions you have or have had in the past.

□ AIDS	□ Chemical Dependency	□ High Cholesterol	□ Prostate Problem
□ Alcoholism	□ Chicken Pox	□ Psychiatric Care	□ Polio
□ Anemia	□ Diabetes	□ Kidney Disease	□ Rheumatic Fever
□ Anorexia	□ Emphysema	□ Liver Disease	□ Cataracts
□ Appendicitis	□ Epilepsy	□ Measles	□ Stroke
□ Arthritis	□ Glaucoma	□ Migraine Headaches	□ Suicide Attempt
□ Asthma	□ Goiter	□ Thyroid Problems	□ Cataracts
□ Bleeding Disorders	□ Mononucleosis	□ Tonsillitis	□ Pneumonia
□ Multiple Sclerosis	□ Tuberculosis	□ Hernia	□ Cancer
□ Bronchitis	□ Heart Disease	□ Mumps	□ Typhoid Fever
□ Bulimia	□ Hepatitis	□ Pacemaker	□ Ulcers

MEDICATIONS List medications you are currently taking.	ALLERGIES to medications.

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Signature of patient, parent, or guardian Date