**Ne’ to’ meyr Program - HEALTH HISTORY QUESTIONNAIRE**

**THIS DOCUMENT IS CONFIDENTIAL UNDER CHAPTER 1, SECTION VII.E OF THE YUROK TRIBE TITLE IV-E POLICIES AND PROCEDURES**

**Applicant Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Physical Health is:** [ ]  Good [ ]  Poor Has changed in past year? [ ]  Yes [ ]  No

**Do you have or have you ever had any of the following medical conditions?**

|  |  |
| --- | --- |
| [ ]  Allergies[ ]  Anemia[ ]  Arterial Sclerotic Disease[ ]  Arthritis[ ]  Asthma[ ]  Birth Defects[ ]  Blind/Visual Impairment[ ]  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Carpal Tunnel Syndrome[ ]  Chronic Lung Disorder[ ]  Chronic Pain[ ]  Cirrhosis[ ]  Congestive Heart Failure[ ]  Cystic Fibrosis[ ]  Deaf/Hearing Impairment[ ]  Diabetes[ ]  Digestive Disorders (Reflux, Irritable Bowel Syndrome, Colitis)[ ]  Ear Infections[ ]  Epilepsy/Seizures[ ]  Head Injury[ ]  Heart Disease[ ]  Hepatitis/Jauntice | [ ]  Hypercholesterolemia[ ]  Hyperlipidemia[ ]  Hypertension (High Blood Pressure)[ ]  Hyperthyroidism[ ]  HIV[ ]  Infertility[ ]  Meningitis[ ]  Migraines[ ]  Multiple Sclerosis[ ]  Muscular Dystrophy[ ]  Obesity[ ]  Osteoporosis[ ]  Other Neurological[ ]  Parkinson’s Disease[ ]  Physical Disability[ ]  Psoriasis[ ]  Rheumatic Fever[ ]  Sexually Transmitted Infection[ ]  Stroke[ ]  Tinnitus[ ]  Tuberculosis[ ]  Ulcers[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**WOMEN ONLY:** Are you currently pregnant? [ ]  Yes [ ]  No [ ]  Don’t know

**Allergies:** Do you have allergies to, or have reacted adversely to, any of the following items?

[ ]  Local anesthesia or dental anestetics [ ]  Penicillin [ ]  Sulfa drugs [ ]  Aspirin

[ ]  Barbiturates, sedatives or sleeping pills [ ]  Other antibiotics [ ]  Iodine

[ ]  Allergies/reactions to any other drugs or food: please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **No Known Allergies**

**Have you ever had any of the following problems?**

|  |  |  |
| --- | --- | --- |
| [ ]  Eye disease, injury, or impaired sight[ ]  Ear disease, injury, or impaired hearing[ ]  Loss of consciousness[ ]  Fainting spells[ ]  Convulsions[ ]  Paralysis[ ]  Dizziness[ ]  Frequent or severe headaches[ ]  Trouble with nose, sinuses, mouth, or throat[ ]  Enlarged thyroid or goiter[ ]  Enlarged glands[ ]  Loss of appetite[ ]  Extreme tiredness or weakness | [ ]  Skin disease[ ]  Chronic or frequent cough[ ]  Chest pain or angina[ ]  Coughing up blood[ ]  Night sweats[ ]  Varicose veins[ ]  Shortness of breath[ ]  Palpitations/fluttering of heart[ ]  Back, arm, or leg problems[ ]  Kidney disease or stones[ ]  Bladder disease[ ]  Swelling of hands, feet, or ankles[ ]  Protein, sugar, blood in urine[ ]  Difficulty urinating[ ]  Abnormal thirst | [ ]  Frequent urination[ ]  Indigestion[ ]  Depression or anxiety[ ]  Suicidal thoughts[ ]  Difficulty concentrating[ ]  Hallucinations[ ]  Crying spells[ ]  Appendicitis[ ]  Liver or gallbladder disease[ ]  Hemorrhoids/rectal bleeding[ ]  Constipation or diarrhea[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Are you currently under the care of a primary health care provider (for example, doctor, nurse practitioner, clinic)?**

[ ]  Yes [ ]  No Condition for which you receive treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current primary health care provider’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current primary health care provider’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization for Release of Information signed to all sharing of information? [ ]  Yes [ ]  No

**Family History:** Has anyone in your immediate family had any of the following illnesses?

[ ]  Diabetes [ ]  Cancer [ ]  Heart disease [ ]  Overweight [ ]  Stroke

[ ]  High blood pressure [ ]  Seizure [ ]  Other neurological disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information, other significant illnesses, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History:** Please check and explain as appropriate if you have any history of treatment for the following illnesses listed below:

[ ]  Depression [ ]  Schizophrenia [ ]  Bipolar [ ]  Substance Use [ ]  Suicide Attempt

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment History:

|  |
| --- |
|  |

Number of psychiatric hospitalizations (*best estimate*) for self in: \_\_\_Past year \_\_\_Past 5 years \_\_\_Lifetime

**Family History:** Please check and explain if there is any history of treatment for your family members:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Parent:** | [ ] Depression | [ ] Schizophrenia | [ ] Bipolar | [ ] Substance Use | [ ] Suicide Attempt | [ ] Other |
| **Sibling:** | [ ] Depression | [ ] Schizophrenia | [ ] Bipolar | [ ] Substance Use | [ ] Suicide Attempt | [ ] Other |
| **Child:** | [ ] Depression | [ ] Schizophrenia | [ ] Bipolar | [ ] Substance Use | [ ] Suicide Attempt | [ ] Other |
| **Aunt/Uncle:** | [ ] Depression | [ ] Schizophrenia | [ ] Bipolar | [ ] Substance Use | [ ] Suicide Attempt | [ ] Other |
| **Grandparent:** | [ ] Depression | [ ] Schizophrenia | [ ] Bipolar | [ ] Substance Use | [ ] Suicide Attempt | [ ] Other |
| If Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medication History:** Please provide medications for the past two years. Record the highest dose given.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Medication | Currently taking? | Dose | Frequency | Start/Stop Dates | Prescribed By | How effective are these medications at treating your symptoms? | Well tolerated? |
| 1. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 2. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 3. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 4. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 5. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 6. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 7. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 8. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 9. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |
| 10. | [ ] Yes[ ] No |  |  |  |  | [ ] Full[ ] Minimal | [ ] Partial[ ] None | [ ] Yes[ ] No |

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**Comments:** Please make additional comments if needed to clarify.

|  |
| --- |
|  |
| Applicant Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ne’ to’ Meyr Program Staff Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |