**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 | | | | | | | |

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

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