YUROK TRIBE

Health & Human Services Division
Tribal Child Welfare & Behavioral Health Department
Title IV-E Program

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

190 Klamath Boulevard • Post Office Box 1027 • Klamath, CA 95548
(707) 951-6631 or (707) 482-1350

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: _____

190 Klamath Boulevard • Post Office Box 1027 • Klamath, CA 95548
(707) 951-6631 or (707) 482-1350

Ne' to' Meyr Program Staff Signature: _____ Date: _____

190 Klamath Boulevard • Post Office Box 1027 • Klamath, CA 95548
(707) 951-6631 or (707) 482-1350