Oconee Center for Behavioral Health

1360 Caduceus Way Building 400, Suite 102,
Watkinsville, Georgia 30677
Ph: 706-286-8442 Fx: 706-310-6907

Medical History Questionnaire

Chief Complaint:_____

_____

_____

_____

Stressors: Given the list of categories below, how much stress is each currently causing you. If you are filling this out on behalf of the patient, please answer from the patient's perspective.

	None	Mild Stress	Moderate Stress	Severe Stress
Family	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Educational	☐	☐	☐	☐
Economic	☐	☐	☐	☐
Occupational	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Legal	☐	☐	☐	☐
Health	☐	☐	☐	☐

Review of Symptoms: Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the Above" for that area. If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Constitutional	Eyes	Ears, Nose, Mouth & Throat
☐ Chronic Pain	☐ Eye Pain	☐ Earache
☐ Loss of Appetite	☐ Eye Discharge	☐ Tinnitus (Ringing in Ears)
☐ Increase in Appetite	☐ Eye Redness	☐ Decreased Hearing or Loss
☐ Unexplained Weight Loss	☐ Blurred or Double Vision	☐ Frequent Ear Infections
☐ Weight Gain	☐ Visual Change	☐ Frequent Nose Bleeds
☐ Fatigue/ Lethargy	☐ History of Eye Surgery	☐ Sinus Congestion
☐ Unexplained Fever	☐ Sensitivity to Light	☐ Runny Nose/ Post-Nasal Drip
☐ Hot or Cold Spells	☐ Scotomas (Blind Spots)	☐ Difficulty Swallowing
☐ Night Sweats	☐ Retinal Hemorrhage (Floaters in Vision)	☐ Frequent Sore Throat
☐ Sleeping Pattern Disruption	☐ Amaurosis Fugax (Feeling like a curtain is pulled over vision)	☐ Prolonged Hoarseness
☐ Malaise (Flu-like or Vague Sick Feeling)	☐ None of the above Eye Issues	☐ Pain in Jaw or Tooth

☐ None of the Above Constitutional Issues
☐ Other _____
_____
_____
_____
_____
_____

☐ Other _____
_____
_____
_____
_____
_____
_____

☐ Dry Mouth

☐ None of the Above Ear, Nose, Mouth, or Throat Issues
☐ Other _____
_____
_____

Cardiovascular

☐ Chest Pain
☐ Pacemaker
☐ Palpitations (fast or irregular heartbeat
☐ Swollen Feet or Hands
☐ Fainting Spells
☐ Shortness of Breath w/ Exercise
☐ None of the Above Cardiovascular Issues
☐ Other _____
_____
_____
_____
_____
_____
_____

Respiratory

☐ Pain with Breathing
☐ Chronic Cough
☐ Chronic Shortness of Breath
☐ Chronic Wheezing/ Asthma
☐ Excessive Phlegm
☐ Coughing Blood
☐ Nocturnal Dyspnea (Shortness of Breath at Night)
☐ None of the Above Respiratory Issues
☐ Other _____
_____
_____
_____
_____
_____
_____

Musculoskeletal

☐ Swelling in Joints
☐ Redness of Joints
☐ Other Joint Pains or Stiffness
☐ Muscle Pain or Cramping
☐ Muscle Weakness
☐ Muscle Stiffness
☐ Decreased Range of Motion
☐ Back Pain or Stiffness
☐ History of Fractures
☐ Past Injury to Spine or Joints
☐ None of the Above Musculoskeletal Issues
☐ Other _____
_____

Allergic/ Immunologic

☐ Frequent Infections
☐ Hives
☐ Anaphylaxic Reaction
☐ None of the Above Allergic or Immunologic Issues
☐ Other _____
_____
_____
_____
_____
_____

Endocrine

☐ Severe Menopausal Symptoms
☐ Cold or Heat Intolerance
☐ Excessive Appetite
☐ Excessive Thirst or Urination
☐ Excessive Sweating
☐ None of the Above Endocrine Issues
☐ Other _____
_____

Hematologic/ Lymphatic

☐ Blood Clots
☐ Excess/ Easy Bleeding (Surgery, Dental Work, Brushing Teeth, Scrapes)
☐ History of Blood Transfusion
☐ Excessive Bruising
☐ Swollen Glands (neck, Armpits, Groin)
☐ None of the Above Hematologic or Lymphatic Issues
☐ Other _____
_____

Gastrointestinal

☐ Excessive Flatulence or Belching
☐ Diarrhea
☐ Constipation
☐ Persistent Nausea/ Vomiting
☐ None of the Above Gastrointestinal Issues

☐ Abdominal Pain
☐ Difficulty Swallowing Solids or Liquids
☐ Heartburn
☐ Recent Loss of Appetite
☐ Sensitivity to Milk Products
☐ Other _____
_____

☐ Jaundice (Yellow Skin)
☐ Change in Appearance of Stool
☐ Blood in Stool
☐ Dark/ Tarry Stool
☐ Loss of Bowel Control/ Soiling

Genitourinary (General)

☐ Loss of Urine Control (Including Bed-Wetting)
☐ Painful/ Burning Urination
☐ Blood in Urine
☐ Increased Frequency of Urination
☐ Up More than twice a night to Urinate
☐ Urine Retention
☐ Frequent Urine Infections
☐ None of the Above General Genitourinary Issues
☐ Other _____
_____
_____
_____

Genitourinary (Women)

☐ Unusual Vaginal Discharge
☐ Vaginal Pain, Bleeding, Soreness or Dryness
☐ Genital Sores
☐ Heavy or Irregular Periods
☐ No Menses (Periods Stopped)
☐ Currently Pregnant
☐ Sterility/ Infertility
☐ Any Other Sexual or Sex Organ Concerns
☐ None of the Above Sex-specific Genitourinary Issues
☐ Other _____
_____

Genitourinary (Men)

☐ Slow Urine Stream
☐ Scrotal Pain
☐ Lump or Mass in the Testicles
☐ Abnormal Penis Discharge
☐ Trouble Getting/ Maintaining Erections
☐ Inability to Ejaculate/ Orgasm
☐ Any Other
☐ Any Other Sexual or Sex Organ Concerns
☐ None of the Above Sex-specific Genitourinary Issues
☐ Other _____
_____

Neurological

☐ Paralysis
☐ Fainting Spells
☐ Dizziness/ Vertigo
☐ Drowsiness
☐ Slurred Speech
☐ Speech Problems (Other)
☐ Short Term Memory Trouble
☐ Memory Difficulties (Loss)
☐ Frequent Headaches
☐ Muscle Weakness
☐ Numbness/ Tingling Sensations
☐ Neuropathy (Numbness in Feet)
☐ Tremor in Hands/ Shaking
☐ None of the Above Neurological Issues
☐ Other _____
_____

Integumentary (Skin/ Breast & Hair)

☐ Lesions
☐ Unusual Mole
☐ Easy Bruising
☐ Increased Perspiration
☐ Rashes
☐ Chronic Dry Skin
☐ Itchy Skin or Scalp
☐ Hair or Nail Changes
☐ Hair Loss
☐ Breast Tenderness
☐ Breast Discharge
☐ Breast Lump or Mass
☐ None of the Above Integumentary Issues
☐ Other _____
_____
_____

Psychiatric

☐ Feeling Depressed
☐ Difficulty Concentrating
☐ Phobias/ Unexpected Fears
☐ No Pleasure From Life Anymore
☐ Anxiety
☐ Insomnia
☐ Excessive Moodiness
☐ Stress
☐ Disturbing Thoughts
☐ Manic Episodes
☐ Confusion
☐ Memory Loss
☐ Nightmares
☐ None of the Above Psychiatric Issues
☐ Others _____
_____

Substance Abuse History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have a history of any recreation drug use? ☐ Yes ☐ No

If YES, please fill out the table below to the best of your knowledge:

Substance Used:	YES	NO	Age of First Use	Age of Last Use	How was it Taken?	Amount per Day	Days per Month
Amphetamines/ Speed	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Barbiturates/ Downers	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Opiates	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Cocaine	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Psychedelics (e.g. LSD, Ecstasy, Bath Salts)	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Inhalants (e.g. Glue, Aerosols)	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Cannabis/ Marijuana/ Hashish	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
Benzodiazepines	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____
PCP	☐	☐	_____	_____	☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected	_____	_____

Substance Abuse Treatment History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Did you receive any Treatment for Substance Abuse? ☐ Yes ☐ No

If YES, please fill out the table below to the best of your knowledge:

Treatment Type	Yes	No	How many episodes of treatment?	Age of first treatment?	Age of last treatment?	Any Additional Treatment Information?
Inpatient	☐	☐	_____	_____	_____	_____
Intensive Outpatient	☐	☐	_____	_____	_____	_____
Outpatient	☐	☐	_____	_____	_____	_____
12-Step Program	☐	☐	_____	_____	_____	_____

Substance Abuse Consequences: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Have you ever experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please Check All That Apply)

☐ No Consequences
☐ Felt that you need to cut down on our drinking?
☐ Been annoyed by others criticizing your drinking?
☐ Felt guilty about drinking?
☐ Needing a drink first thing in the morning?
☐ Increased Tolerance
☐ Withdrawal (shakes, sweating, nausea, rapid heart rate)
☐ Seizures
☐ Blackouts
☐ Effects on Physical Health
☐ Using/ consuming more than intended
☐ Unintentional overdose
☐ DUI
☐ Arrests
☐ Physical fights or assaults
☐ Relationship conflicts
☐ Problems with money
☐ Job loss or problems at work/ school
☐ Other _____
_____
_____
_____
_____

Inpatient History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have a history of inpatient psychiatric treatment? ☐ Yes ☐ No

Please List any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Hospital/ Facility	Treatment Voluntary?	Primary Reason for Hospitalization	How old were you?	Treatment Outcome	Additional Comments
	☐ Yes ☐ No		_____		
	☐ Yes ☐ No		_____		
	☐ Yes ☐ No		_____		
	☐ Yes ☐ No		_____		
	☐ Yes ☐ No		_____		

Outpatient History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have a history of outpatient psychiatric treatment? ☐ Yes ☐ No

Provider	Reason for Seeking Treatment	Age of First Treatment	Age of Last Treatment	Outcome	Additional Comments
		_____	_____		
		_____	_____		
		_____	_____		
		_____	_____		
		_____	_____		

Suicide/ Self Harm History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Have you ever tried to harm or kill yourself? ☐ Yes ☐ No

Was your intent to die? ☐ Yes ☐ No

Elaborate: _____

_____

_____

_____

How many times in your life has this occurred? _____

Please describe your most severe episode including date, method, and consequences: _____

_____

_____

_____

Please describe your most recent episode including date, method, and consequences: _____

_____

_____

_____

Violence History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Have you had any history of violent behavior? ☐ Yes ☐ No

If YES, please elaborate: _____

_____

_____

_____

Past Medical History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Who is your primary care physician? _____

Are you taking any medications currently? (Excluding medications for psychiatric treatment) ☐ Yes ☐ No

If YES, please list medications: _____

_____

_____

_____

Have you had a history of any of the following health problems? (Please Check All That Apply)

☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Cancer
☐ Cataracts
☐ Chickenpox (as a child)
☐ Chronic Bronchitis
☐ COPD (Emphysema)
☐ Diabetes
☐ Diverticulitis
☐ Fainting Spells/ Passing Out
☐ High Cholesterol
☐ Hearing Loss
☐Heart Disease
☐ Heart Defect From Birth
☐ Heart Valve Problems
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ HIV
☐ Hypertension
☐ Hypotension
☐ Inflammatory Bowel Disease
☐ Iron Deficiency
☐ Multiple Sclerosis
☐ Obesity/ Overweight
☐ Parkinson's Disease
☐ Polyps
☐ Seizures
☐ Sexually Transmitted Disease
☐ Sleep Apnea
☐ Stroke/TIA
☐ Testosterone (low)
☐ Thyroid Problems
☐ Tuberculosis or exposure
☐ No problems
☐ Other _____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had a history of surgery un any if the following areas? (Please Check All That Apply)

☐ Back/ Neck
☐ Brain
☐ Cardiac
☐ Ear/ Nose/ Throat
☐ Gall Bladder
☐ Hernia
☐ Hip/ Knee/ Ankle/ Foot
☐ Hysterectomy (Ovaries Removed)
☐ Hysterectomy (Ovaries Retained)
☐ Intestine
☐ Kidney
☐ Liver
☐ Lung
☐ Pancreas
☐ Pelvis
☐ Penis
☐ Other _____
☐ Prostate
☐ Sex Change
☐ Shoulder/ Elbow/ Wrist/ Hand
☐ Stomach
☐ Tonsils
☐ Vagina
☐ Weight Loss
☐ No Surgical History

_____

Psychiatric Medication History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Have you ever taken any medication for psychiatric treatment? ☐ Yes ☐ No

If YES, please fill out the table below to the best of your knowledge:

Medication Name	Dose	How Long? (months)	End Date	Therapeutic Effect	Side Effects	Reasons for Stopping

Patient Allergies: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have any known allergies to medication? ☐ Yes ☐ No

If YES, please fill out your allergy information below:

Medication	Allergic Reaction

Family History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Do you have any family members with a history of psychiatric illness? ☐ Yes ☐ No

If YES, please elaborate: _____
_____
_____
_____

Is there any additional family medical history? _____

Developmental and Educational History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

During your pregnancy/ birth, did your mother have any problems with any of the following:

- ☐ Exposure to drugs or alcohol during pregnancy
- ☐ A Difficult Pregnancy
- ☐ Problems with Delivery
- ☐ None of These
- ☐ Other _____
  _____

Did you have any complications after your birth? ☐ Yes ☐ No

Did you have any delays or difficulties in reaching the following the developmental milestones?

- ☐ Walking
- ☐ Talking
- ☐ Toilet Training
- ☐ None of These
- ☐ Sleeping Alone
- ☐ Being Away from Parents
- ☐ Making Friends
- ☐ Other _____

Which options below best describe your childhood home atmosphere?

- ☐ Normal
- ☐ Supportive
- ☐ Parental Fighting
- ☐ Parental Violence
- ☐ Financial Difficulties
- ☐ Frequent Movements
- ☐ Other _____

Which of the following challenges were experienced during your childhood?

- ☐ Tantrums
- ☐ Enuresis (Bed Wetting)
- ☐ Encopresis (Fecal Incontinence)
- ☐ Running Away From Home
- ☐ Fighting
- ☐ Stealing
- ☐ Property Damage
- ☐ Fire Setting
- ☐ Animal Cruelty
- ☐ Separation Anxiety
- ☐ Victim of Bullying
- ☐ Depression
- ☐ Death of a Parent/ Caregiver
- ☐ Parental Divorce
- ☐ None of These
- ☐ Other _____

Which of the following best describes problems you may have had in school?

- ☐ Fighting
- ☐ School Phobia
- ☐ Truancy
- ☐ Detentions
- ☐ Suspensions
- ☐ Expulsions
- ☐ School Refusal
- ☐ Class Failures
- ☐ Repetition of Grades
- ☐ Special Education
- ☐ Remedial Classes
- ☐ None of These

Did you have additional schooling outside of the standard classroom setting?

- ☐ Speech Classes
- ☐ Tutoring
- ☐ Other _____
- ☐ Accommodations
- ☐ None of These

Please indicate your highest Level of Education: _____

If you have any further comments about your development or educational history and wish to elaborate further: _____
_____
_____
_____

General Social History: If you are filling this out on behalf of the patient, please answer the patient's perspective.

Which options below best describes your social situation?

☐ Supportive Social Network
☐ Few Friends
☐ Substance-use based friends
☐ Other _____
☐ No Friends
☐ Distant from Family of Origin
☐ Family Conflict

What is your current marital status? ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Other

What is the status of your intimate relationship? _____

What is the satisfaction level of your intimate relationship? _____

What is sexual orientation? _____

What is current living situation? _____

Who do you currently live with?

☐ Live Alone
☐ Roommates
☐ Partner/ Souse
☐ Other _____
☐ Parent(s)
☐ Sibling(s)
☐ Children

Do you currently participate in spiritual activities? _____

What is your current occupation status? _____

What is your current yearly income? _____

What is your longest period of continuous employment? _____

What is your longest period of continuous unemployment? _____