Aroga
Behavioral Health of Princeton
keeping good health in mind

Name:_____ Date:_____

HEALTH HISTORY QUESTIONNAIRE

Do you have or have you ever had:

- ☐ Hypertension
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Headaches
- ☐ Bleeding Disorder
- ☐ Sinus Problems
- ☐ Other _____
- ☐ Other _____

Surgeries:

- ☐ Appendix
- ☐ Gallbladder
- ☐ Tonsils
- ☐ Adenoids
- ☐ Thyroid
- ☐ Other _____
- ☐ Other _____

Hospitalizations:

Date:	Where:	For:

Please list all prescription medications, including birth control, over-the-counter medications, herbal or homeopathic remedies, or supplements you are taking:

_____

_____

Please list all mental health and alcohol or substance abuse treatment including therapy, counseling, psychologist, psychiatrist, outpatient group programs, inpatient programs, and ECT.

Date	Type of treatment	Name of provider or organization

Please list psychiatric medications that have been tried in the past:

Medication	Date From-To	Dose	Benefits	Side effects	Reason stopped

_____
Patient signature

____/____/____
Date

_____
Reviewed by M.D.

____/____/____
Date