psych care
associates, p.c.

Health Questionnaire

Patient Name: _____DOB: _____
Date:_____ Email: _____ Phone:_____

Pharmacy:_____ Pharmacy Address:_____
Insurance Carrier:_____Issue Date:_____
Insurance ID #:_____ Rx Bin: _____PCN: _____Rx Grp: _____

Please give us as much information as you can about your prior medical history. If possible, give dates, medication doses, names and phone numbers of treating doctors.

How would you characterize your health, in general, in the past:
(Circle one) **Excellent** **Good** **Average** **Poor** **Awful**
How would you characterize your health, right now:
(Circle one) **Excellent** **Good** **Average** **Poor** **Awful**

Do you have any serious or chronic medical conditions now or in the past? ☐ Yes ☐ No
_____
_____
_____

Have you been hospitalized, or had any operations or surgical procedures? ☐ Yes ☐ No
_____
_____
_____

List the medicines you are taking right now:

_____
_____
_____
_____
_____
_____

List the medicines you have taken in the past:

_____
_____
_____
_____
_____
_____

Please list your family physician and your other recent doctor and therapists:
_____
_____

Any Allergies to Medications: ☐ Yes ☐ No
List medications: _____
_____
_____

Current Weight: _____Current Height:_____
Race:_____ Ethnicity: _____
Language: _____

Please indicate if **any biologically related family member** suffers from any of these medical problems:

_High blood pressure
_Cardiac problems
_Heart attacks
_Respiratory problems
_Asthma
_Diabetes mellitus
_Hyperthyroidism
_Hypothyroidism
_Liver problems
_Kidney problems
_Arthritis
_Lupus
_Cancer
_Seizures
_Stroke
_Migraines
_Dementia
_Alzheimer's disease
_Parkinson's disease
_Multiple Sclerosis

Please indicate if **any biologically related family member** suffers from any of these neuropsychiatric problems:

_Mental retardation
_Depression
_Bipolar disorder
_Anxiety
_ADD/ADHD
_Obsessive Compulsive disorder
_Schizophrenia
_Psychosis or hallucinations
_Tourette's syndrome
_Learning Disability
_Suicide attempts
_Psychiatric hospitalization
_Anger problems
_Alcoholism
_Drug abuse
_Autism/Asperger's

Other important family information that we ought to know:

_____

_____

Please indicate if **you** have any of these problems:

_Skin conditions
_Frequent Headaches
_Migraines
_Past head injury
_Loss of consciousness
_Dizziness/Vertigo
_Glasses/contact lenses
_Blurry vision
_Double vision
_Cataracts
_Glaucoma
_Hearing loss
_Ringing in the ears
_Back pain
_Motor tics
_Memory loss
_Diabetes mellitus
_Changes to hair
_Bruise easily
_Gallstones
_Arthritis
_Nose bleeds
_Frequent sinusitis
_Seasonal allergies
_Sore throat
_Respiratory problems
_Shortness of breath
_Asthma
_Frequent cough
_Chest pain
_Cardiac problems
_Heart murmur
_Heart attack
_High cholesterol
_Poor coordination
_Hyperthyroid
_Stroke
_Heat/cold intolerance
_Fatigue
_Past blood transfusions
_Liver problems
_High blood pressure
_Abdominal pain
_Heartburn/reflux
_Ulcers
_Nausea/vomiting
_Diarrhea/constipation
_Frequent urinary infections
_Frequent urination
_Incontinence
_Kidney stones
_Gynecological problems
_Muscle weakness
_Joint pain
_Numbness/Tingling
_Hypothyroid
_Seizures
_Weight gain/loss
_Anemia
_Blood disorder
_Hernias
_Menopause/Hormone Replacement Therapy
_Other:_____

_____

What are your most troublesome problems at this time?

_____

_____

_____

Past or present use of:

Tobacco: ☐ Yes ☐ No
Alcohol: ☐ Yes ☐ No
Drugs: ☐ Yes ☐ No

Thanks for giving us this information. It will be treated with the utmost discretion. We do, however, routinely communicate relevant information with other treating health professionals and with family members, when appropriate. It is a privilege for us to serve you at Psych Care Associates, and we appreciate your confidence.

Our website is www.pcaludlow.com

Our patient portal login is https://2941.portal.athenahealth.com/

Our phone number is 413.583.6750

Our fax number is 833.974.2219