University of Pennsylvania Health System
Health Information Questionnaire Page 1

Name_____

MRN ___ ___ ___ ___ ___ ___ ___ ___ ___

Date _____

Answer each of the following questions to the best of your ability. This will help us understand how we can help you best. If you prefer, you may discuss these questions directly with your doctor or therapist.

Please give us a brief description of why you came to the clinic today: _____

_____

_____

Is this a new problem? ☐ YES ☐ NO If NO, please tell us when it first started: _____

_____

D: Have you been feeling down or depressed most of the time lately? ☐ YES ☐ NO If YES, for how long? _____
H: Have you thought about not wanting to live or about hurting yourself? ☐ YES ☐ NO
H: Have you thought about harming somebody else? ☐ YES ☐ NO
If you answered YES to either of the last two questions, please describe your thoughts: _____

_____

M: Over the last several days, have you been feeling particularly happy and full of energy? Or, have you been feeling stronger, faster, sexier, or smarter than your usual self? ☐ YES ☐ NO
M: Have you been more irritable or gotten in more arguments or fights than is usual for you? ☐ YES ☐ NO

If you answered YES to either of the last two questions, please describe: _____

_____

P: Have you been hearing things that other people cannot hear, like noises or voices? ☐ YES ☐ NO

If you answered YES, please describe: _____

_____

P: Is someone or something outside of you controlling your thinking, putting thoughts in your head, or stealing your thoughts? ☐ YES ☐ NO
P: Does it seem like people are watching you a lot or plotting against you?

_____
If you answered YES to either of the last two questions, please describe: _____

_____

A: Are you having panic or anxiety attacks when you suddenly feel very nervous, anxious, or worried? ☐ YES ☐ NO
A: Do you repeat behaviors that are hard to stop, like washing your hands, counting, or checking things? ☐ YES ☐ NO

If you answered YES to either of the last two questions, please describe: _____

_____

E: Do you have eating binges or feel that your eating is out of control? ☐ YES ☐ NO If YES, please describe:

_____

C: Have you been absentminded or had any trouble with your memory? ☐ YES ☐ NO
C: Has anyone talked to you about problems with your memory? ☐ YES ☐ NO
If you answered YES to either of the last two questions, please describe: _____

_____

T: During the last few weeks, has anyone been abusive to you? ☐ YES ☐ NO

☐ Physically ☐ Emotionally ☐ Verbally ☐ Sexually

Medical Problems: Do you have medical problems? Had any surgery? Had any serious injuries?

Problem/Surgery/Injury	When did this start or happen?

Medications: Please list all medications that you take. Include medications that have been prescribed for you by any doctor as well as medications or dietary supplements that you purchase yourself.

Name of medication	Dose/Frequency	Why do you take this medication?	When was your last dose?

Allergies: Please list all allergies that you have:

_____

_____

Health Concerns:

If you are having problems in any area listed below, please place a checkmark (✓) next to it. If you are not sure, place a question mark (?).

_____Headaches
_____Fainting or dizziness
_____Seizures or convulsions
_____Eyes or ears
_____Nose, throat, neck
_____Breathing
_____Heart
_____Stomach or abdomen
_____Muscles or joints
_____Back
_____Skin
_____Passing urine
_____Bowel movement
_____Sexual problems
_____Diabetes
_____High blood pressure
_____Cancer
_____HIV or AIDS
_____Hepatitis or cirrhosis
_____Tuberculosis -TB

Women Only:

_____Breasts
_____Vagina
_____Pregnant

Men Only:

_____Penis
_____Testicles

FOR CLINICIAN USE ONLY:

Please place a checkmark (✓) in the squares that will us The most accurate understanding of your use of alcoholic beverages, medications and other drugs.

1. How often do you have a drink of beer, wine, or liquor?
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2 to 4 times a month
   - ☐ 2 to 3 times a week
   - ☐ 4 or more times a week

2. When you drink, how much do you usually have?

   ____ Beer ____Glasses Wine ____Shots ____Mixed Drinks

3. How often do you have six or more drinks in a day?
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly
   - ☐ Weekly
   - ☐ Daily or almost daily

4. How often do you take a pain medication or something for your nerves such as Xanax or Valium?
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2 to 4 times a month
   - ☐ 2 to 3 times a week
   - ☐ 4 or more times a week

5. When you take medication for pain or for stress how many do you usually take?

   ____ Number of pills a day

6. How often do you use any street drugs?
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2 to 4 times a month
   - ☐ 2 to 3 times a week
   - ☐ 4 or more times a week

7. Which street drug do you use? Check (✓) all that apply.

☐ Heroin/opiates ☐ Cocaine/Crack ☐ Pot/Marijuana
☐ Hallucinogens (LSD, XTC, 'Shrooms ☐ Glue/Inhalants

8. When you use drugs, how much do you usually take in a single day (for example: $100 worth of crack/$160 of heroin?)

   Amount spent in a day? $ _____

9. How often do you use more than $10 worth of street drugs?
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly
   - ☐ Weekly
   - ☐ Daily or almost daily

FOR CLINICIAN USE ONLY:

10. Do you ever have trouble limiting your drinking, medication or drug use?

    ☐ YES ☐ NO

11. How often have you forgotten to do what you were supposed to b/c of your drinking, medication or drug use?
    - ☐ Never
    - ☐ Less than monthly
    - ☐ Monthly
    - ☐ Weekly
    - ☐ Daily or almost daily

12. How often do you take a drink, drug, or medication so that you can start your day?
    - ☐ Never
    - ☐ Less than monthly
    - ☐ Monthly
    - ☐ Weekly
    - ☐ Daily or almost daily

13. How often do you feel guilty about your drinking, medication or drug use?
    - ☐ Never
    - ☐ Less than monthly
    - ☐ Monthly
    - ☐ Weekly
    - ☐ Daily or almost daily

14. How often has your drinking, medication or drug use interfered with your memory?
    - ☐ Never
    - ☐ Less than monthly
    - ☐ Monthly
    - ☐ Weekly
    - ☐ Daily or almost daily

15. Has anyone, including yourself, ever been injured as a result of your drinking, medication, or drug abuse?

    ☐ YES ☐ NO

16. Has anyone ever suggested that you cut back or try to control your drinking, medication or drug use?

    ☐ YES ☐ NO

17. Which do you use the most (Check ONE only)?
    - ☐ Alcohol (beer, wine, liquor)
    - ☐ Marijuana
    - ☐ Heroin (or other opiates)
    - ☐ Cocaine or Crack
    - ☐ Tranquilizers (sedatives, sleeping pills)
    - ☐ Hallucinogens (LSD, XTC, ‘Shrooms, PCP)
    - ☐ Amphetamines (Speed, Ice)
    - ☐ Glue/Inhalants

FOR CLINICIAN USE ONLY: