BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE

San Luis Obispo Behavioral Health Department	☐ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX (805) 781-1227	☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177

Medical Providers:

Check any of the providers listed below you currently receive services from or have received from in the last 5 years.

☐Community Health Center ☐Private Community Physician ☐Hospital Emergency Rooms
☐Urgent Care Center ☐Pain Management Services ☐Specialty Medicine (i.e., Neurology, Cardiology, Endocrinology)
☐Dentists ☐Methadone Clinics

General Health Information

1. Date you last saw a Doctor / Nurse Practitioner / Physician Assistant:	2. What was the purpose of the visit?	3. Date of your last physical exam?

4. ☐ How many times have you visited an Emergency Room in the past 30 days?
5. ☐ How many days in past 30 have you stayed overnight in a hospital for physical health problems?
6. ☐ How many days in the past 30 have you experienced physical health problems?
7. ☐Yes ☐No Have you ever had surgery? If yes, please list**:**
8. ☐Yes ☐No Any other illness that requires frequent medical attention? If yes, please give details:

Allergies

9. ☐Yes ☐No Do you have any allergies? If yes, *what type of reaction did you have?* Fill out below-🡻

Medication Allergies -

Food Allergies -

Other Allergies -

Medications

10. Please list any prescribed medications and over-the-counter medications you take regularly. (Include dosage and prescribing physician)

MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN

11. Which Pharmacy do you use?

12. Are you currently experiencing or do you have any of the following?

Yes	No		Yes	No	
☐	☐	Swollen Ankles	☐	☐	Seizures
☐	☐	Jaundice	☐	☐	Headaches
☐	☐	Sinus Problems	☐	☐	Weight Gain or Loss Recently
☐	☐	Bleeding Problems - Bruising Easily	☐	☐	Shortness of Breath
☐	☐	Joint Pain or Stiffness	☐	☐	Blood Transfusions
☐	☐	Difficulty Swallowing	☐	☐	Arthritis
☐	☐	Chest Pain (Angina)	☐	☐	Stroke - If yes, give details: _____
☐	☐	Excessive Heartburn or Abdominal Pains	☐	☐	High Blood Pressure
☐	☐	Excessive Thirst	☐	☐	Low Blood Pressure
☐	☐	Cough, Persistent or Bloody	☐	☐	Artificial Joint
☐	☐	Chronic Back Pain	☐	☐	Head Injury - If yes, give details: details: _____
☐	☐	Tooth or Gum Problems	☐	☐	Cancer
☐	☐	Nausea or Vomiting	☐	☐	Chemotherapy/Radiation
☐	☐	Diarrhea, Constipation, Blood in Stools	☐	☐	Diabetes
☐	☐	Dizziness or fainting	☐	☐	Asthma, Emphysema, or Chronic Bronchitis
☐	☐	Frequent or Bloody Urination	☐	☐	Anemia
☐	☐	Rashes	☐	☐	Heart Attack or Heart Problem - If yes, please give details:
☐	☐	Blurred or Double Vision			
☐	☐	Fever			

CLIENT NAME	**CLIENT NUMBER**

13. Women Only

Yes No
☐ ☐ Are you pregnant? If yes, due date: _____
☐ ☐ Are you breastfeeding? If yes, date of delivery: _____
☐ ☐ Have you had any miscarriages or abortions? If yes, please give details: _____
☐ ☐ Do you have difficult periods? If yes, please give details: _____
At what age did you start your first period? _____
Date of last period: _____

Yes No
☐ ☐ Have you experienced any domestic violence?
☐ ☐ Do you have pain with intercourse?
☐ ☐ Have you had an abnormal mammogram or lump? If yes, please give details: _____
☐ ☐ Have you had an abnormal PAP smear? If yes, please give details: _____
Date of last GYN exam: _____

Communicable Diseases

14. ☐Yes ☐No Have you ever been tested for TB? (Tuberculosis)?
15. ☐Yes ☐No Have you ever had a positive TB Test? Date of last TB Test or last chest X-ray: _____

16. ☐Yes ☐No Have you been diagnosed with Hepatitis C? Date of last test: _____
17. ☐Yes ☐No Have you been tested for any other liver disease?

18. ☐Yes ☐No Have you been diagnosed with a Sexually Transmitted Disease (STD)? 19. ☐Yes ☐No Did you get treated?	Date of last STD Test?
20. ☐Yes ☐No Have you been tested for HIV? 21. ☐Yes ☐No Did you receive the test result?	Date of last HIV Test?

Mental Health

22. ☐Yes ☐No Have you ever been diagnosed with a mental illness? If yes, what was your diagnosis? _____
23. ☐Yes ☐No Did you receive treatment? If yes, please give details:

24. ☐ How many times in the last 30 days have you received outpatient emergency services for mental health needs?

25. ☐ How many days in the last 30 have you stayed 24 hours or more in a hospital or psychiatric health facility for mental health needs?

26. ☐Yes ☐No In the past 30 days have you taken prescribed medication for mental health needs, including medication for anxiety?

27. ☐Yes ☐No Past suicide attempts?	28. Date of last suicide attempt:	29. How many suicide attempts in your lifetime?

Alcohol and Other Drugs

30. **Do you use the following substances and how frequently:**	**Daily**	**Often**	**Sometimes**	**Date last used**
Alcohol→				
Other substances→				

31. ☐Yes ☐No Have you ever injected drugs?
32. ☐Yes ☐No Have you shared needles?
33. ☐Yes ☐No Have you shared cottons?

34. ☐ How many days in the past 30 have you injected drugs?	Last time injected drugs:

35. ☐Yes ☐No Have you ever used SLO Co. Needle Exchange?

36. ☐Yes ☐No Are you in withdrawal today? If yes, list from what substance(s)?

37. ☐Yes ☐No Seizures, delirium tremens? If yes, please give details:

38. ☐Yes ☐No Have you had blackouts? If yes, please give details:

39. ☐Yes ☐No Are you currently smoking / ingesting marijuana? → ☐Yes ☐No Medical Marijuana Card?	Date last smoked/ingested marijuana:
40. ☐Yes ☐No Have you ever overdosed on alcohol or other drugs?	If Yes, please give details:

41. ☐Yes ☐No Do you currently use any tobacco products (cigarettes, electronic cigarettes, chew)?

To the best of my knowledge the above information is accurate and true, and I will inform my provider of changes in my health or medications:

Client Signature: **Date:**

Staff Signature: **Date:**

CLIENT NAME	**CLIENT NUMBER**