



MERITUS HEALTH, INC

Behavioral Health Services Health History – (Confidential)

Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is your reason for visit? _____

SYMPTOMS Check (x) symptoms you currently have or have had in the past year:

GENERAL	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Itching
<input type="checkbox"/> Depression	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Extreme Stress	<input type="checkbox"/> Rash
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Hazardous Exposure	<input type="checkbox"/> Sores that won't heal
<input type="checkbox"/> Fainting	GASTROINTESTINAL	<input type="checkbox"/> Heavy Lifting	MEN ONLY
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Poor Appetite	EYE, EAR, NOSE, THROAT	<input type="checkbox"/> Breast/Testicle Lump
<input type="checkbox"/> Hearing Voices/Hallucinations	<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> Chronic Blurred Vision	<input type="checkbox"/> Erection Difficulties
<input type="checkbox"/> Nervousness/Anxiety	<input type="checkbox"/> Chronic Stomach Pains	<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> Penis Sore/Discharge
NEUROLOGICAL	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Chronic Nose Bleeds	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Seizure Activity	<input type="checkbox"/> Excessive Thirst/Hunger	<input type="checkbox"/> Difficulty Swallowing	WOMEN ONLY
<input type="checkbox"/> Weakness or numbness in	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Pregnant - Due Date: _____
<input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Legs <input type="checkbox"/> Hips	UROLOGICAL	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> History of Miscarriages
<input type="checkbox"/> Feet <input type="checkbox"/> Shoulders <input type="checkbox"/> Back	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Ringing in Ears	Last Period: _____
CARDIOVASCULAR	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Extreme Menstrual Pain
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lack of Bladder Control	<input type="checkbox"/> Sinus Problems/Hay Fever	<input type="checkbox"/> Bleeding Between Periods
<input type="checkbox"/> Easy Bruising/Varicose Veins	<input type="checkbox"/> Painful Urination	SKIN	Last Pap Smear: _____
<input type="checkbox"/> High/Low Blood Pressure	OCCUPATIONAL/HEALTH	<input type="checkbox"/> Change in Moles	<input type="checkbox"/> History of Abnormal Paps

CONDITIONS Check (x) conditions you or a blood relative have or have had in the past:

Me	Blood Relative	Me	Blood Relative	Me	Blood Relative	Me	Blood Relative
<input type="checkbox"/>	<input type="checkbox"/> AIDS	<input type="checkbox"/>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Breast Lumps
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> HIV Positive	<input type="checkbox"/>	<input type="checkbox"/> Pacemaker
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Drug Misuse	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/> Anorexia	<input type="checkbox"/>	<input type="checkbox"/> Emphysema	<input type="checkbox"/>	<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/> Appendicitis	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Migraines	Dates of Blood transfusions: _____	
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Goiter	<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis		
<input type="checkbox"/>	<input type="checkbox"/> Asthma/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia	IMMUNIZATIONS	
<input type="checkbox"/>	<input type="checkbox"/> Bronchitis	<input type="checkbox"/>	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Normal Childhood	
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/> Up-to-Date	
<input type="checkbox"/>	<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Suicide Attempts	<input type="checkbox"/> Flu	

FAMILY HISTORY	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Sisters				
Brothers				

HOSPITALIZATIONS, SERIOUS ILLNESS, INJURIES OR PREGNANCIES

Year	Nature or Reason	Complications or Outcomes

Patient Signature: _____ RN Signature: _____

Official use only – Medical, Safety, Fall Risk Need for Follow-up; Provide details: _____

PLACE LABEL HERE