HILL ALCOHOL AND DRUG TREATMENT

HEALTH QUESTIONNAIRE

Name: _____ Date: _____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. **This information is confidential.**

Section 1 Please answer Yes or No. If YES, please give dates and details.

1. Do you **currently** have any **contagious** health problems or illnesses (such as tuberculosis or active pneumonia).

☐ **N** ☐ **Y**

a. When did the condition start?_____

b. Who is the treating health care provider?_____

c. What medication do you take for this condition?_____

d. What else are you doing to help this condition?_____

e. How is the medication and/or other interventions working?_____

2. Are you running a fever today?

☐ **N** ☐ **Y**

a. When did the condition start?_____

b. Who is the treating health care provider?_____

c. What medication do you take for this condition?_____

d. What else are you doing to help this condition?_____

e. How is the medication and/or other interventions working?_____

3. Do you have a rash or skin lesions with drainage now?

☐ **N** ☐ **Y**

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

Section 2 Please answer Yes or No. If YES, please give dates and details.

4. Have you ever had a stroke?
☐ **N** ☐ **Y**
a. When did the condition occur?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

5. Have you ever had a head injury that resulted in a period of loss of consciousness?
☐ **N** ☐ **Y**
a. When did the condition occur?_____
b. How long were you unconscious? _____
c. Do you still have problems such as dizziness or loss of memory? _____
d. Who is the treating health care provider? _____
e. What medication do you take for this condition? _____
f. What else are you doing to help this condition? _____
g. How is the medication and/or other interventions working? _____

6. Have you experienced or suffered any chest pains recently? ☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

7. Have you ever been diagnosed with MRSA? ☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider?_____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

Section 3 Please answer Yes or No. If YES, please give dates and details.

8. Have you ever had a heart attack or any problem associated with the heart?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

9. Have you ever had blood clots in the legs or elsewhere that required medical attention?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

10. Have you ever had high-blood pressure or hypertension?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

11. Do you have a history of cancer?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

Section 4 Please answer Yes or No. If YES, please give dates and details.

12. Do you have a history of any other illness that may require frequent medical attention?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

13. Do you have any allergies to medications, foods, animals, chemicals, or any other substance?
☐ **N** ☐ **Y**
a. What are you allergic to?_____
b. What is your specific allergic reaction?_____
c. Who is the treating health care provider? _____
d. What medication do you take for this condition? _____
e. What else are you doing to help this condition? _____
f. How is the medication and/or other interventions working? _____

14. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation?
☐ **N** ☐ **Y**
a. What is the specific condition? _____
b. When did the condition occur?_____
c. Who is the treating health care provider? _____
d. What medication do you take for this condition? _____
e. What else are you doing to help this condition? _____
f. How is the medication and/or other interventions working? _____

15. Have you ever been diagnosed with diabetes?
☐ **N** ☐ **Y**
a. When was the condition diagnosed?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

Section 5 Please answer Yes or No. If YES, please give dates and details.

16. Have you ever been diagnosed with any type of hepatitis or other liver illness?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

17. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for any type of glandular disease?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

18. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis?
☐ **N** ☐ **Y**
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

19. Do you use nicotine? ☐ **N** ☐ **Y**
a. _____packs/day for _____years.
b. Do you desire to quit? ☐ **N** ☐ **Y**
c. Have you quit before? ☐ **N** ☐ **Y**
d. How long did you quit for? _____
e. What method did you use to quit? _____

Section 6 Please answer Yes or No. If YES, please give dates and details.

20. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with kidneys or bladder?

☐ **N** ☐ **Y**

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

21. Do you have any of the following:

Arthritis ☐ **N** ☐ **Y** When did the condition start?_____

Back Problems ☐ **N** ☐ **Y** When did the condition start?_____

Bone Injuries ☐ **N** ☐ **Y** When did the condition start?_____

Muscle Injuries ☐ **N** ☐ **Y** When did the condition start?_____

Joint Injuries ☐ **N** ☐ **Y** When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication(s) do you take for the condition(s)? _____

d. What else are you doing to help the condition(s)? _____

e. How is the medication and/or other interventions working? _____

f. Additional info: _____

22. Have you had any surgeries or hospitalizations due to illness or injury? ☐ **N** ☐ **Y**

Date of incident: _____Please describe:_____

_____

Date of incident: _____Please describe:_____

_____

Date of incident: _____Please describe:_____

_____

Date of incident: _____Please describe:_____

_____

Section 7 Please answer Yes or No. If YES, please give dates and details.

23. When was the last time you saw a physician including a psychiatrist?_____
What was the purpose of the visit? _____
_____

24. Do you take any prescription psychiatric medications?
☐ **N** ☐ **Y**
Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

25. Do you wear or need to wear glasses, contact lenses, or hearing aids?
☐ **N** ☐ **Y** Details: _____

26. Do you have difficulty hearing?
☐ **N** ☐ **Y** Details: _____

27. Do you have difficulty reading?
☐ **N** ☐ **Y** Details: _____

28. When was your last dental exam? Date:_____

29. Are you in need of dental care?
☐ **N** ☐ **Y** Details: _____
a. What has prevented you from getting care? _____
_____

30. Do you wear or need to wear dentures or other dental appliances?
☐ **N** ☐ **Y** Details: _____

31. Are you pregnant? ☐ **N** ☐ **Y**

Section 8 DETOX RISK ASSESSMENT

32. State of General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

33. Have withdrawal symptoms occurred when you have become abstinent in the past?
☐ **N** ☐ **Y** Details: _____
How many withdrawal episodes have you experienced?_____

34. Have you ever had a seizure or DT's?
☐ **N** ☐ **Y** Date: _____
a. Cause of seizure: _____

35. Last date that substance was used?
Alcohol: _____ Tranquilizers:_____
Painkillers: _____ Sleeping Medications: _____

36. Are you currently experiencing any of the following?

1. Extreme Anxiety	☐ **N**	☐ **Y**	7. Visual Distortions	☐ **N**	☐ **Y**
2. Tremors	☐ **N**	☐ **Y**	8. Auditory Hallucinations	☐ **N**	☐ **Y**
3. Diaphoresis (sweating)	☐ **N**	☐ **Y**	9. Tactile Hallucinations	☐ **N**	☐ **Y**
4. Nausea/Vomiting	☐ **N**	☐ **Y**	10. Insomnia	☐ **N**	☐ **Y**
5. Diarrhea	☐ **N**	☐ **Y**	11. Loss of appetite	☐ **N**	☐ **Y**
6. Muscle Cramps	☐ **N**	☐ **Y**	12. Cravings	☐ **N**	☐ **Y**

Section 9 HIV ASSESSMENT

1. Have you ever used IV drugs? ☐ **N** ☐ **Y**

2. If you are currently using IV drugs…
Is the injection area infected or abscessed? ☐ **N** ☐ **Y**

3. Have you ever participated in unsafe or unprotected sex? ☐ **N** ☐ **Y**

4. Have you had a blood transfusion? ☐ **N** ☐ **Y**

5. Have you been sexually active with an IV drug user? ☐ **N** ☐ **Y**

6. Have you been tested for HIV? ☐ **N** ☐ **Y**

When: _____ Results:_____

Referral for HIV Test to: _____

7. Do you identify self as part of LBGT Community? ☐ **N** ☐ **Y**

Section 10 FAMILY MEDICAL HISTORY

37. Has a 1st degree relative had the following:

☐ **N** ☐ **Y** Addiction
☐ **N** ☐ **Y** Asthma
☐ **N** ☐ **Y** Cancer
☐ **N** ☐ **Y** Diabetes
☐ **N** ☐ **Y** Stroke
☐ **N** ☐ **Y** Rheumatoid Arthritis
☐ **N** ☐ **Y** Depression
☐ **N** ☐ **Y** Bi-Polar Disorder
☐ **N** ☐ **Y** Heart Disease
☐ **N** ☐ **Y** Lupus
☐ **N** ☐ **Y** Blood clots

If yes to any of the above, please complete the following:

Condition	**Family Member**	**Type of Medication Prescribed/Used**	**Response to Medication**
Example- Depression	Mom	Prozac	Good

_____	_____
Patient Signature	Date
_____	_____
Program Nurse Signature	Date