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)

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
<th>PRESCRIBING PHYSICIAN</th>
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11. Which Pharmacy do you use?

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

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<th></th>
<th>Yes</th>
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Yes | No
---|---
Seizures | Headaches
Weight Gain or Loss Recently | Shortness of Breath
Blood Transfusions | Arthritis
Stroke - If yes, give details: | High Blood Pressure
Low Blood Pressure | Artificial Joint
Head Injury - If yes, give details: | Cancer
Chemotherapy/Radiation | Diabetes
Asthma, Emphysema, or Chronic Bronchitis | Anemia
Heart Attack or Heart Problem - If yes, please give details:

CLIENT NAME

CLIENT NUMBER
13. **Women Only**

- 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: ______________________

**Communicable Diseases**

- Have you ever been tested for TB? (Tuberculosis)?
- Have you ever had a positive TB Test? Date of last TB Test or last chest X-ray: ______________________
- Have you been diagnosed with Hepatitis C? Date of last test: ______________________
- Have you been tested for any other liver disease? ______________________

- Have you ever been tested for HIV? Date of last HIV Test: ______________________
- Have you been diagnosed with a mental illness? If yes, what was your diagnosis? ______________________
- Have you ever received treatment? If yes, please give details: ______________________

**Alcohol and Other Drugs**

- Do you use the following substances and how frequently:
  - Alcohol
  - Other substances

<table>
<thead>
<tr>
<th>Substance</th>
<th>Daily</th>
<th>Often</th>
<th>Sometimes</th>
<th>Date last used</th>
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</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<tr>
<td>Other substances</td>
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</tbody>
</table>

- Have you ever injected drugs?
- Have you shared needles?
- Have you shared cottons?
- Last time injected drugs: ______________________

- Have you ever used SLO Co. Needle Exchange?
- Are you in withdrawal today? If yes, list from what substance(s)?
- Seizures, delirium tremens? If yes, please give details:
- Have you had blackouts? If yes, please give details:
- Are you currently smoking / ingesting marijuana? Date last smoked/ingested marijuana: ______________________
- Medical Marijuana Card? If Yes, please give details:
- Have you ever overdosed on alcohol or other drugs? If Yes, please give details:
- 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: ______________________

CLIENT NAME: ______________________  CLIENT NUMBER: ______________________