
**KINGDOM MINISTRIES MENTAL HEALTH & PSYCHIATRY
MEDICAL HISTORY QUESTIONNAIRE FOR
VOLUNTARY ADMISSION TO A MENTAL HEALTH FACILITY**

Name: _____ Date of Birth: _____

Date: _____ Identity no: _____

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

Section 1

*** To be filled in by General Medical Practitioner or Professional Nursing Sister**

1. Name and Surname of Medical Practitioner / Professional Nursing Sister: (Please print)

2. Name of Practice / Clinic / Institution:

3. Tel no: _____ Fax no: _____ Cell no: _____ Email: _____

Questionnaire (To be addressed to the Applicant)

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.

No Yes Date: _____

2. Have you ever had a stroke? If yes, please give details.

No Yes Date: _____

3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.

No Yes Date: _____

4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.

No Yes Date: _____

5. Have you experienced or suffered any chest pains? If yes, please give details.

No Yes Date: _____

6. Have you ever had a heart attack or any problem associated with the heart? If yes, please Give details.

No Yes Date: _____

7. Do you take any medications for a heart condition? If yes, please give details.

No Yes Date: _____

8. Have you ever had high-blood pressure or hypertension? If yes, please give details.

No Yes Date: _____

9. Do you have a history of cancer? If yes, please give details.

No Yes

10. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If yes, please give details.

No Yes

11. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.

No Yes Date: _____

12. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.

No Yes

13. Please describe any surgeries or hospitalisations due to illness or injury that you have had.

Date: _____

14. Do you take prescription medications for any physical conditions? If yes, please list type(s) and dosage(s).

No Yes

15. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.

No Yes

16. When was your last dental exam?

Date: _____

17. Do you take any contraceptive medication? Please give details and date of last injection.

No Yes

18. Is there any other information regarding your physical health that you need to bring to our attention?

No Yes

19. I, _____ declare that the above information is true and correct to the best of my knowledge. I declare that a copy of all relevant prescriptions is attached to this Questionnaire

Signature: _____

Date: _____

Section 2

*** To be filled in ONLY by a Psychiatrist or Professional Psychiatric Nursing Sister**

1. Name and Surname of Psychiatrist / Professional *Psychiatric* Nursing Sister: (Please print)

2. Name of Practice / Clinic / Institution:

3. Tel no: Fax no: Cell no: Email:

Questionnaire

1. Psychiatric Diagnosis: DSM IV/R Classification:

Axis I

Axis II

Axis III

Axis IV

Axis V

2. Date of first diagnoses:

3. Approximately how many admissions did the Applicant have to a psychiatric hospital?

4. Date and length of latest admission?

5. At what hospital did the Applicant receive In patient treatment?

File no: Tel no:

6. At what last hospital / clinic did the Applicant receive Out patient treatment?

File no: Tel no:

7. Medication and dosage:

8. Name of Psychiatrist / Psychiatric Nursing sister acquainted with the Applicant:

9. Does the Applicant have a history of, or incidents of violence or aggression? If yes, please give details./4

No Yes

10. Does the Applicant have a history of substance abuse? If yes, please give details.

No Yes

11. Has the Applicant ever experienced suicidal ideations in the past or made suicidal attempts? If yes, please give details.

No Yes

12. Does the Applicant have sexual preoccupation or any sexual issues which have been identified? If yes, please give details.

No Yes

13. Does the Applicant have a gender identity disorder which has been identified? If yes, please give details.

No Yes

14. Was the Applicant admitted voluntary or compulsory to the psychiatric hospital?

No Yes

15. Is there a history or incidents of the Applicant missing or stopping treatment?

No Yes

16. Describe mood swings e.g. extremes of "highs" or "lows".

17. Describe any problems with disorientation / memory loss / other.

18. List and describe any other psychiatric / medical information not listed in this questionnaire, e.g. sleeplessness, etc. Describe any other problems that may warrant our attention:

19. I, _____ declare that the above information is true and correct to the best of my knowledge. I declare that a copy of all relevant prescriptions is attached to this Questionnaire.

Signature:

Date:

For Office use:

I, _____ (name of KMT Nursing Sister) declare that I have received this Questionnaire on the _____, and handed the original to the Director of Medical & Mental Health KMT.

Signature:

Date:
