MEDICAL HISTORY QUESTIONNAIRE p 1

I. MEDICAL HISTORY

YES	NO	Please check (√) YES or NO for each item listed. If YES, furnish details, including date and name of doctor.
		1. During the last 5 years have you:
YES	NO	A. Been treated for any medical condition or surgical condition? (specify)
YES	NO	B. Had an Xray, EKG, or laboratory test? (specify)
YES	NO	C. Been advised to have an operation? (specify)
		D. Date of last physical exam: _____ by Dr._____
YES	NO	2. During the last 5 years have you taken any prescription or non-prescription MEDICATIONS?
		Medication: Dosage: Date Started: Date Ended: Prescribing MD:
YES	NO	3. Do you have any ALLERGIES to medications, food, or other? (specify)
YES	NO	4. Have you had any HOSPITALIZATIONS (medical or psychiatric)?
		Year of Hospitalization(s): Hospital Name: Reason for Hospitalization: Length of Stay:
YES	NO	5. Do you drink CAFFEINE products (coffee, tea, soda)? How much?
YES	NO	6. Do you SMOKE? How much?
YES	NO	7. Do you drink ALCOHOL? How much and how often?
YES	NO	8. Except as prescribed by a MD, have you taken any of the following DRUGS? (please indicate date of last use use and typical amount)
		• heroin • morphine • sedatives • other narcotics • cocaine • tranquilizers • LSD, hallucinogens • amphetamines • marijuana • barbiturates • other drugs

II. FAMILY HISTORY INFORMATION:

	Living? (Y or N)	Age or Age at Death	History of Emotional Problem?	History of Medical Problem?	Describe Emotional Problem, Medical Problem, Cause of Death if noted
Father	Y N		Y N	Y N	
Mother	Y N		Y N	Y N	
Sister(s)	Y N		Y N	Y N	
Brother(s)	Y N		Y N	Y N	

CLIENT NAME: _____DATE_____

Social Security Number:_____HEIGHT_____WEIGHT_____

MEDICAL HISTORY QUESTIONNAIRE p 2

III. REVIEW OF SYMPTOMS Have you ever had, or been told you have had the following?

NEVER HAD	HAVE NOW	HAD IN PAST	SYMPTOM	NEVER HAD	HAVE NOW	HAD IN PAST	SYMPTOM
			sleep disturbance				tuberculosis
			dizziness or fainting				heart trouble/ heart attack
			palpitations or pounding heart				high blood pressure
			shortness of breath				kidney disease
			chronic fatigue				stroke
			stomach pains				jaundice/liver disease
			chronic pain				arthritis/ gout/rheumatism
			headaches (severe or often)				AIDS/ HIV positive
			eating too much/too little				hypoglycemia
			tremor or shakiness				tumor/cancer
			indigestion, nausea, gas				rheumatic fever
			constipation, diarrhea, colitis				venereal disease
			recent weight: • gain/• loss				diabetes
							anemia
			nosebleeds				paralysis
			unusual bleeding				epilepsy/seizures
			eye problem/glaucoma				neurological disease/neuritis
			hearing problem/earaches				lupus
			head injury				ulcer
			thyroid trouble (too low/high)				multiple sclerosis
			asthma				urination, painful or frequent
			chronic cough				stomach/bowel disease
			FEMALES: treated for any OB/GYN disorder or change in menstrual patterns?				
			FEMALES: currently pregnant or planning a pregnancy in the near future?				
			MALES: prostate trouble				

♦ **Please list any other disease or condition you may have that is not listed above:**

♦ **Please provide information related to "yes" answers above, such as: date(s) of occurrence, duration, and name of Doctor who treated you:**