2017

HEALTH SCREENING

Patient's Name _____ Date _____

Date of Birth_____ Sex ____ F _____ M

Allergies _____

1. Do you have or have you ever had any of the following?
(Please check yes or no)

Please describe No or Yes

_____
Allergies _____
Blood Disorder _____
Bone or joint problems _____
Cancer _____
Diabetes _____
Endocrine Disorders (e.g. thyroid) _____
Epilepsy (seizures, convulsions) _____
Gastrointestinal Disorders (stomach)_____
Head Injury _____
Heart Disease _____
HIV/AIDS related conditions _____
Hypertension (high blood pressure) _____
Hypoglycemia (low blood sugar) _____
Liver Disease_____
Lung Disease _____
Physical Limitations _____
Sexually Transmitted Disease (e.g. gonorrhea, syphilis) _____
Other _____

2.HOSPITALIZATIONS: (list any operations, medical procedures, mental, drug, or alcohol abuse treatment)

Date Procedure/treatment

_____
_____
_____
_____
_____
_____
_____

3.MEDICATION: currently taking (include prescription drugs; amount and frequency)

Name of Medication Amount Frequency Date Started

_____
_____
_____
_____
_____

4. MEDICAL PROCEDURES: Physical exams; special test e.g. EKG, Blood tests,X-rays, within past year.

Exam/ Test Performed Date Physician/ Clinic

5. PRIMARY CARE DOCTOR:
Name Address Phone
Date of last Physical exam

_____
_____
_____

6.PREVIOUS MENTAL HEALTH TREATMENT:

Date Name of Provider Address Phone

_____
_____
_____
_____

Parent/guardian/ patient's signature _____ Date_____