BRIEF HEALTH QUESTIONNAIRE

NAME: ______________________________________ **DATE**: ____________________

Please list the names of all medical specialists you have seen over the past 5 years:

OB-GYN: ____

OTHERS: ____

____

Please indicate presence of any major medical problems:

	NO / YES		NO / YES
Heart Disease	_____ _____	**Head Injury**	_____ _____
Hypertension	_____ _____	**Seizures/Epilepsy**	_____ _____
Asthma/Respiratory	_____ _____	**Neurological Disorder**	_____ _____
Stomach/GI Problems	_____ _____	**HIV+/AIDS**	_____ _____
Liver Disease	_____ _____	**Visually Impaired**	_____ _____
Renal Disease	_____ _____	**Hearing Impaired**	_____ _____
Cancer	_____ _____	**Other:** ___________________	_____ _____

Please list all medications you take regularly:

Prescribed Medications:

Name/ Dose/ How often Prescribed/ Date started

__________________________ _____________ ______________ _________________ __________

__________________________ _____________ ______________ _________________ __________

__________________________ _____________ ______________ _________________ __________

Over-the-counter Medications:

____

____

Do you have any drug allergies? NO ______ YES ______

Please list: ____

Do you have any other allergies? NO ______ YES ______

Please list: ____

Have you had any adverse reactions to medication or other substances? YES_____ NO_____

If yes, describe ____

Do you consume products with caffeine? NO ______ YES ______

Describe: ______________________________ How much: ______________________

Do you drink alcohol? NEVER ______ IN PAST/NOT NOW ______ YES ______

How Much? ______________________________

Do you use tobacco? NEVER ______ IN PAST/NOT NOW ______ YES ______

How Much? ______________________________

Do you use any other drugs? NEVER______ IN PAST/NOT NOW______

YES______

Do you exercise regularly? NO ______ YES ______

Have you ever had mental health or substance abuse treatment? NO ______

YES______

Name of Provider /When Treated /Response

___________________________ __________________ ____________________

___________________________ __________________ ____________________

___________________________ __________________ ____________________

This information is part of a confidential medical record.