BRIEF HEALTH QUESTIONNAIRE

NAME: ______________________________________ **DATE**: ____________________

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

OB-GYN: ____

PEDIATRICIAN: ____

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 by	Date started
______________________	_____________	______________	_________________	__________
______________________	_____________	______________	_________________	__________
______________________	_____________	______________	_________________	__________
______________________	_____________	______________	_________________	__________
______________________	_____________	______________	_________________	__________

Over-the-counter Medications:

______________________ ______________ _________________

______________________ ______________ _________________

______________________ ______________ _________________

(OVER)

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
______________________________	____________________	______________________
______________________________	____________________	______________________
______________________________	____________________	______________________