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:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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.