Brief Health Information Form

A. Identification

Client's name: _____ Case #: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications, drugs, or other substances you take or have taken in the last year–prescribed, over-the-counter vitamins, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get? _____
_____
_____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? Which? _____
_____

3. Do you try to restrict your eating in any way?

How? _____

Why? _____

4. Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems? _____
_____

E. For women only

At what age did you start to menstruate?_____

2. Menstrual period experiences:

a. How regular are they? _____

b. How long do they last? _____

c. How much pain do you have? _____

d. How heavy are your periods? _____

e. Other experiences during periods? _____

Please list all of your pregnancies:

	What happened with this pregnancy?			
Your age	Miscarriage	Abortion	Child born	Problems?
1.				
2.				
3.				
4.				
5.				
6.				

4. Menopause:

a. If your menopause has started, at what age did it start? _____

b. What signs or symptoms have you had? _____

_____

_____

F. Other

Do you use tobacco ❑ No ❑ Yes. Yes. If yes, how many cigarettes/cigars/other do you use each day? _____

Have you ever injected drugs? ❑ Yes ❑ No Ever shared needles? ❑ Yes ❑ No

Have you had HIV testing in the last 6 months? ❑ Yes ❑ No. If yes, results: _____

Are there any other medical or physical problems you are concerned about? _____

_____

_____

_____