# Medical Questionnaire

Please take a moment to fill out the following brief medical survey for yourself or your child. Some questions may not apply to you. Please mark the "does not apply" or "DNA."

Name: ___________________________________________ Date of Birth: _____________

| Age | Height | Weight | Sex | If female: | Pregnancies | Live Births |
|---|---|---|---|---|---|---|
| ___ | _____ | _____ | ___ | | _______ | ______ |

Current Physician or Pediatrician: _______________________________________________

Last Medical Examination: _______________________________________

Previous Mental Health Treatment or Counseling: ______________________________________

__________________________________________________________________________________

| Hospitalization: | Date | Description: (e.g., appendectomy, depression |
|---|---|---|
| | _____ | ___________________________________________ |
| | _____ | ___________________________________________ |
| | _____ | ___________________________________________ |
| Trauma: broken bones, head injury | _____<br>_____ | ___________________________________________<br>___________________________________________ |

Current ongoing medical problems: (heart of lung disease, allergies, epilepsy, diabetes, etc.)

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Current Medications: (including frequent use of over the counter medications)

__________________________________________________________________________________

__________________________________________________________________________________

History of reactions to medications:

__________________________________________________________________________________

__________________________________________________________________________________

Medical Questionnaire continued

Current symptoms: Answer yes or no unless otherwise indicated.

Recent weight gain or loss _____, amount ______, over what time period ______.

Headaches _______. If yes, how often, describe ____________________________

Dizziness ________ Fainting __________

Visual problems _______. If yes, describe ____________________________________

Hearing problems ______. If yes, describe ____________________________________

Chest pain _______. Shortness of breath ______. Other breathing problems ___________.

Abdominal pain ________. If yes, describe ______________________________________

Problems with urination. ______. If yes, describe (bedwetting, frequent urinations) _____
_______________________________________

Sexual problems __________________

Sleep disturbances ______. If yes, describe _________________________________________

Do you drink? ______ How much? _______ Is it a concern to you? _____________________
Has it been a concern to others? ______ Have you tried to stop? ______________________

Do you smoke? _______

Do you use "recreational" drugs? _______ Which ones? ____________________________
How often? _______________

Do you have any habits that have concerned you or others (e.g., eating habits such as binge eating, excessive dieting, behavioral habits such as excessive hand washing)? _____________