WEST SLOPE CASA
MEDICAL HISTORY QUESTIONNAIRE

_____ ____/____/____ ____/____/____
Client Name Date of Birth Today's Date

_____
Name of Person Providing Information (if different from client) Relationship to Client

_____
Client's Primary Care Physician (Name, Address, Phone Number)

I. FAMILY HISTORY AGE (or age at death) Present Health or Cause of Death

Father _____ _____

Mother _____ _____

Sister (s) _____ _____ _____ _____ _____ _____

Brother (s)_____ _____ _____ _____ _____ _____

II. HEALTH HISTORY

1.	Please list the date of your last physical exam and the results:	
2.	Describe any <u>current</u> medical illness or condition that you have, and who is providing treatment:	
3.	Describe any <u>past</u> medical illness or condition and who provided treatment:	
4.	List any operations you have had:	
5.	List any prescription medications that you are presently taking (If none, write NONE):	
6.	List any non-prescription medications that you are presently taking (Please describe name and dosage; If none, write NONE):	
7.	List any allergies you have to any medications (If none, write NONE):	
8.	Have you ever had a bad reaction to any medication (If YES, please give name(s) and describe reaction; If none, write NONE):	
9.	Has anyone in your family (or a distant blood relative) experienced any emotional or psychiatric problems? (If YES, please describe):	

III. SECTION III

10. How much alcohol do you drink? _____

11. How much do you smoke?_____

12. How much coffee, tea, or soda do you drink? _____

13. Have you ever tried to cut back on the amount you drink? Yes No

14. Have you ever tried to cut back on the amount you smoke? Yes No

15. Have you ever taken substances not prescribed by a physician? Yes No

16. Have you ever taken too much over-the-counter medication? Yes No

REVIEW OF SYMPTOMS: Have you ever experienced any of the following complaints or conditions? For each symptom or condition, please check ONE of the three boxes. If you currently have a symptom and have had it in the past, check "have now" column only.

NEVER HAD	HAVE NOW	HAD IN PAST	CHECK ONE FOR EACH SYMPTOM	NEVER HAD	HAVE NOW	HAD IN PAST	CHECK ONE FOR EACH SYMPTOM
			Frequent or severe headaches				Numbness
			Dizziness				Neck or back problems
			Loss of consciousness				Chronic pain
			Head injury				Chronic fatigue or weakness
			Thyroid problems				Swelling of extremities
			Anemia				Sleeping too much or too little
			Asthma or shortness of breath				Recent weight loss or gain (circle)
			Chronic cough				Frequent diarrhea or constipation (circle)
			Tuberculosis - lung disorder				Frequent stomach cramps
			Palpitation or pounding heart				Appetite loss or gain (circle)
			Heart attack/heart problems				Indigestion
			High blood pressure				Ulcer
			Kidney problems				Diabetes
			Stroke				Frequent or painful urination
			Jaundice or liver problems				Sugar or albumin in urine
			Arthritis/gout				Prostate/Menstrual problems
			Tumors/cancer				Persistent sores or skin problems
			Epilepsy or seizures				Vision problems, including glaucoma
			Dietary restrictions				Hearing loss

Describe any other symptom you have experienced (If none, write NONE)_____

If you answered YES to any of the questions in Section III or indicated any symptoms on the checklist, please prepare to discuss the following questions with your clinician:

1. Have you received treatment?
2. What was the treatment received?
3. Who provided the treatment?
4. What were the results of the treatment?
5. If you did not seek treatment, what was the outcome?