RESOURCE FAMILY APPROVAL (RFA)
HEALTH QUESTIONNAIRE

FOR COUNTY/AGENCY: _____

Applicant Name: *(first, middle, last)*	Date of Birth:

Please provide a listing of your current licensed health professionals *(Name, Address, and Telephone Number)*

Physician: _____
Specialist: _____
Other: _____

Release of Information: I hereby authorize _____ to release the medical information
(Doctor's name)
contained on this form, to the _____ for the purposes of determining my physical
(County/Agency)
health if requested by the County or Agency.

Patient Signature:	Date:

I. Medical History:

What is the date of your last physical exam? _____

Current and/or past diagnosis- Within the last five (5) years, have you been diagnosed with any of the following conditions? Please check all that apply and provide comments if applicable.

☐ Heart Disease	☐ Impaired Sight	☐ Orthopedic Problems (Specify)
☐ Cancer	☐ Heredity Conditions (Specify)	☐ Chronic Medical Conditions
☐ Diabetes	☐ Hypertension	☐ Mental Illness (Specify)
☐ Impaired Hearing	☐ Allergies	☐ Respiratory Condition
☐ Seizure Disorder	☐ Heart Attack	☐ Stroke
☐ Kidney Disease	☐ Thyroid Disease	☐ Chronic Pain
☐ Autoimmune Disease (Specify)	☐ Other Condition or Injury:	

Comments: _____

_____

Are you currently under a physician's care for any of the diagnoses or injuries listed above?

_____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization	Year

Tobacco Usage

Do you smoke cigarettes? _____ If so, how many packs per day? _____

Alcohol Consumption

How many alcoholic beverages do you consume daily? _____

Limits or restrictions on physical activity: _____

II. Medications

(Please list all medications you are currently taking including over the counter medications and medical marijuana. Additional medications can be listed in an attachment.)

Name of Medication	Dosage and Frequency	Condition prescribed for

III . Additional Comments:

_____

_____

_____

IV. Certification

I declare that the above information is true and correct to the best of my knowledge:

Applicant Signature:	Date:

Reminder to Applicant: Please return the completed RFA Health Questionnaire to your assigned RFA worker.