MEDICAL SCREENING

Date _____/_____/_____

Patient Name: _____ Birthday:_____/_____/_____

Part I: Health History/ Systems Review

Does the client have any problems with the following?

Heart disease	Yes	No	High blood pressure	Yes	No
Irrecgular pulse	Yes	No	Palpitations	Yes	No
Asthma/ bronchitis	Yes	No	Coughing blood	Yes	No
Pneumonia	Yes	No	Frequent coughing	Yes	No
Wheezing	Yes	No	Shortness of breath	Yes	No
Frequent diarrhea	Yes	No	Black/tarry stool	Yes	No
Kidney infections	Yes	No	Bladder infections	Yes	No
Painful urination	Yes	No	Blood in urine	Yes	No
Ulcers	Yes	No	Vomiting blood	Yes	No
Liver disease	Yes	No	Jaundice	Yes	No
Gallbladder disease	Yes	No	Fainting	Yes	No
Loss of consciousness	Yes	No	Numbness in limbs	Yes	No
Memory loss	Yes	No	Seizures	Yes	No
Night sweats	Yes	No	Weight gain/loss	Yes	No
Allergies	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Thyroid problems	Yes	No
Problems with eyes	Yes	No	ENT difficulties	Yes	No
Skin lesions	Yes	No	Gynecological system	Yes	No
Urinary problems	Yes	No			

If yes to any of the above, please explain:

MEDICAL SCREENING

Part II: Health History

In the last 30 days has the client used the following:

Alcohol	Yes	No	If yes, Last Use	_____	Quantity	_____
Marijuana	Yes	No	If yes, Last Use	_____	Quantity	_____
Cocaine	Yes	No	If yes, Last Use	_____	Quantity	_____
Amphetamines	Yes	No	If yes, Last Use	_____	Quantity	_____
Opiates (pain killers)	Yes	No	If yes, Last Use	_____	Quantity	_____
Sedativeshypnotics	Yes	No	If yes, Last Use	_____	Quantity	_____
Inhalants	Yes	No	If yes, Last Use	_____	Quantity	_____
Hallucinogens	Yes	No	If yes, Last Use	_____	Quantity	_____
Methadone	Yes	No	If yes, Last Use	_____	Quantity	_____
Other Substances	Yes	No	If yes, Last Use	_____	Quantity	_____

Part III: Health History

Have you ever been tested for? (Date?)

HIV_____ Turberculosis_____ Hepatitis_____

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PROVIDER REVIEW

Comments: _____

_____

_____

_____

Does this client need a physical? YES NO

Referred to: _____

Provider Signature: _____

Date: ____/____/____