NORTH KENT GUIDANCE SERVICES
HEALTH QUESTIONNAIRE

Name: ______________________________________ Case # ________________

Have you ever had, or been treated by a physician for any of the following? (Check if applies)

		YES			YES
1.	Abnormal Fatigue	___	24.	Hepatitis	___
2.	Allergy	___	25.	Hemorrhoid	___
3.	Seizures	___	26.	High Blood Pressure	___
4.	Anemia	___	27.	Impaired Vision	___
5.	Arthritis	___	28.	Indigestion (chronic)	___
6.	Asthma/Hay Fever	___	29.	Jaundice	___
7.	Back Injury/Pain	___	30.	Mononucleosis	___
8.	Bladder/Kidney Difficulties	___	31.	Nervousness or Depression	___
9.	Blood Clots	___	32.	Chest Pain	___
10.	Blood Spitting	___	33.	Rheumatic Fever	___
11.	Chronic Cough	___	34.	Shakes or DT's	___
12.	Cirrhosis of Liver or Pancreatitis	___	35.	Shortness of Breath	___
13.	Dental Disease	___	36.	Sickle Cell Anemia	___
14.	Diabetes	___	37.	Stomach Difficulties	___
15.	Diarrhea (chronic)	___	38.	Thyroid Problems	___
16.	Discharge from Ears	___	39.	Tuberculosis	___
				Date of last skin test______________	
17.	Dizziness	___	40.	Tumors or Cancer	___
18.	Epilepsy	___	41.	Ulcers	___
19.	Fainting Spells	___	42.	Sexually Transmitted Infections	___
20.	Frequent Headaches	___	43.	Vomiting (persistent)	___
21.	Frequent Sore Throat	___	44.	Irregular Heartbeat	___
22.	Gall Bladder/Liver Disease	___	45.	Other: specify___________________	___
23.	Heart Disease	___		* Do not disclose HIV status	

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If any of the preceding questions were answered yes, explain your answers showing the corresponding number:____

____

Are you aware of any additional medical problems? Yes__ No__ If yes, please explain:

____

____

Any recent hospitalizations or surgeries? Yes__ No__ If yes, please explain:

____

Are you aware, or do you believe that any of your past or present physical problems are associated with your chemical use? Yes__ No__ If yes, please explain:

____

Describe your eating/meal habits:____

Describe your exercise habits:____

Date of last physical:______If more than 2 yrs. ago (6 mos. if substance abuse case) clinician verbally recommended physical:Yes___NA___

Date of last consultation with a physician:___________Who:_____________________________

Why:____

List any medications (including birth control pills, vitamins, psychotropic or anticonvulsant) you have previously or are currently taking (specify current or past med, dosage and frequency, Dr.prescribing) and if they were helpful. _____________________________

____

List any medication allergies:____

I certify that the above information is true, complete and correct.

X Patient's Signature:_________________________________ ____________________
Date

____ ____________________

Clinician Reviewer Signature (North Kent Personnel Only) Date
(See Medical Section of Psychosocial history)