NAME	ID#

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD
MEDICAL HISTORY

1. SERIOUS ILLNESSES & CHRONIC CONDITIONS OF SELF, PARENTS, SIBLINGS, ETC. (For example, diabetes, heart trouble,alcohol or other drug abuse/addiction, overactive behavior, depression, cancer, suicide, other)

FAMILY MEMBER (i.e. mother's mother) **CONDITION** (i.e.cancer)

_____ _____

_____ _____

_____ _____

2. CLIENT'S RECENT PHYSICAL COMPLAINTS (MARK "X" NEXT TO SYMPTOMS EXPERIENCED IN THE PAST YEAR)

REPRODUCTIVE HEALTH
__ problems with menstrual cycle
__ symptoms of menopause (i.e. hot flashes, sweating)
__ loss of interest in sex
__ excessive cramping bleeding
__ last menstrual period (women)
Date of last menstrual period :_____

PULMONARY
__ persistent cough
__ breathing problems
__ coughing up phlegm
__ coughing up blood

GENITO-URINARY
__ frequent urination
__ burning on urination
__ trouble initiating urination
__ excessive lower back pain
__ blood in the urine
__ history of sexually transmitted diseases (i.e. gonorrhea, syphilis etc)

ENDOCRINE
__ symptoms of diabetes (i.e. excessive thirst & urination, etc.)
__ symptoms of thyroid dysfunction (i.e. feeling cold, tired, or excessive sweating)

CARDIOVASCULAR
__ chest pains
__ palpitations
__ irregular heartbeat (arrhythmia)
__ swelling in ankles, wrists (edema)
__ high blood pressure symptoms (i.e headaches, nose bleeds)
__ fainting/black outs

GASTROINTESTINAL
__ constipation
__ diarrhea
__ heart burn
__ blood in stool
__ stomach pains

OPHTHALMOLOGICAL
__ visual changes (near or far sighted)
__ blurred vision
__ increased eye pressure

NEUROLOGICAL
__ seizure history
__ headaches (i.e. migraine, tension, cluster)
__ head injuries (loss of consciousness
__ strokes (CVA's)
__ paralysis or numbness
__ any other neurological events, such as sciatica, nerve injuries, etc..

PLEASE ELABORATE ON ANY OF THE MARKED ITEMS, OR OTHER ISSUES THAT MAY NOT BE IDENTIFIED ABOVE:

_____

_____

3. CLIENT'S PAST SERIOUS ILLNESSES (MARK "X" NEXT TO APPROPRIATE ITEMS)

___Infectious Diseases ___Liver disease
___Operations/Medical or surgical hospitalizations ___Other
___Kidney problems

PLEASE ELABORATE ON ANY OF THE MARKED ITEMS:

_____

_____

NAME **ID#**

4. **HAVE YOU EVER HAD PSYCHOLOGICAL, PSYCHIATRIC, OR NEUROLOGICAL EXAMINATIONS? PLEASE LIST WHERE AND WHEN, INCLUDING YOUR MOST RECENT PSYCHIATRIC HOSPITALIZATION, IF APPLICABLE:**

_____

_____

5. **PLEASE LIST ANY MEDICATION(S) YOU HAVE TAKEN THAT DID NOT HELP:**

_____

_____

6. **PLEASE LIST ANY MEDICATION(S) YOU HAVE TAKEN THAT HAVE HELPED:**

_____

_____

7. **PLEASE DESCRIBE YOUR PAST AND CURRENT USE OF PRESCRIPTION MEDICATIONS AND NON PRESCRIPTION MEDICATIONS:**

_____

_____

_____

8. **PLEASE LIST ANY ALLERGIES (INCLUDING MEDICATION ALLERGIES) YOU MAY HAVE:**

_____

_____

9. **PLEASE DESCRIBE YOUR DIETARY HABITS: (**For example: number of meals per day, use of sweets or caffeine, weight changes):

_____

_____

10. **PLEASE DESCRIBE YOUR SLEEP PATTERNS:** (Number of hours per night, sleeplessness, frequent awakenings, nightmares, night sweats):

_____

_____

11. **I MAY BE AT RISK FOR HIV/AIDS. ___YES ___NO ___UNKNOWN**

12. **IS THERE ANY INFORMATION REGARDING YOUR SEXUAL HEALTH THAT WOULD BE IMPORTANT FOR YOUR PHYSICIAN TO KNOW? ___ YES ___ NO**
___ I WILL DISCUSS THIS WITH MY PHYSICIAN (If yes, please elaborate):

_____

_____

13. **IS THERE ANY INFORMATION REGARDING YOUR REPRODUCTIVE HISTORY (MISCARRIAGES, PREGNANCIES) THAT WOULD BE IMPORTANT FOR YOUR PHYSICIAN TO KNOW? ___ YES ___ NO**
___ I WILL DISCUSS THIS WITH THE PHYSICIAN. (If yes, please elaborate):

_____

_____

14. **I HAVE HAD A PERSISTENT COUGH FOR THREE OR MORE WEEKS. ___YES___NO**
(If yes, your therapist will provide you with additional information about TB screening and treatment)

NAME **ID#**

15. UNDER AGE 18 ONLY: IMMUNIZATION STATUS: UP TO DATE: ___YES ___NO
NEEDS_____

16. DO YOU HAVE ANY COMMUNICATION DIFFICULTIES? ____ YES ____ NO
IF YES PLEASE DESCRIBE: ___ HEARING ____ VISION ____ SPEECH ____ READING

17. IS THERE SOMEONE IN YOUR FAMILY WITH A HEARING LOSS? ____ YES ____ NO
a. IF "YES", HOW DOES HIS/HER HEARING LOSS AFFECT YOUR RELATIONSHIP?_____

18. PLEASE CHECK THE BEST DESCRIPTION OF YOUR HEARING ABILITY:

____ No hearing loss
____ Small hearing loss
____Moderate loss
___Severe loss
___Total loss

19. HOW WOULD YOU DESCRIBE YOUR ABILITY TO HEAR OVER THE PHONE?

___Can hear clearly
___Can hear adequately
___Can hear little
___Cannot use the phone

Do you have a text telephone? ___Yes ___No
Do you wear a hearing aid? ___Yes ___No

20. PLEASE FINISH THIS SENTENCE. I CAN UNDERSTAND YOU BEST WHEN YOU…

___Speak in a normal tone
___Speak slowly and carefully
___Speak loudly
___Look at me while you are talking
___Write down your message
___Other:_____

21. MEDICAL DOCTOR:_____ PHONE#_____
ADDRESS: _____

22. DENTIST: _____ PHONE#_____
ADDRESS:_____

23. Request for PHYSICAL EXAMINATION REPORT:

Client does not want to get a physical exam and/or share results with RACSB ___

Client has had an exam within the last 6 months ___ will schedule an exam ___

Staff requested a written release of information for Medical Doctor ___

Staff mailed release and Physical Examination Report to Medical Doctor ___