Options
Counseling and Family Services

Client #:_____

Physical Health & Medical History

A. Please indicate below and provide brief detail for current or past medical problems:

SYSTEMIC	
☐ Recent weight loss	☐ Fatigue
☐ Recent weight gain	☐ Recent fevers or chills
☐ Loss of appetite	☐ Difficulty with sleep
EENT	
☐ Glasses or contact lenses	☐ Hearing loss
☐ Recent change in vision	☐ Ringing in ears
☐ Blurry or double vision	☐ Balance problem
Date of last eye exam:	☐ Earache or drainage
☐ Nosebleeds	☐ Dental problems
☐ Nasal congestion or drainage	☐ Gum problems or bleeding
☐ Sinus problems	☐ Mouth sores
	☐ Recent sore throat
	☐ Difficulty swallowing
	Date of last dental exam:
RESPIRATORY	**CARDIOVASCULAR**
☐ Chronic cough	☐ Chest pain or pressure
☐ Shortness of breath or wheezing	☐ Palpitations (skipped beats)
☐ Asthma	☐ Abnormal heart rhythm
☐ Sleep apnea	☐ Heart murmur
☐ COPD	☐ Heart attack, *specify date:*
☐ Bronchitis, *specify date:*	☐ High blood pressure
☐ Pneumonia, *specify date:*	☐ Elevated cholesterol
☐ Tuberculosis, *specify date:*	☐ Swelling of legs or feet
	☐ Blood clot
ABDOMINAL	**GENITOURINARY**
☐ Abdominal pain	☐ Painful urination
☐ Nausea or vomiting	☐ Urgency or frequency
☐ Frequent heartburn or indigestion	☐ Blood in urine
☐ Ulcer	☐ Incontinence
☐ Constipation	☐ Frequent urinary tract infection
☐ Diarrhea	☐ Kidney stones
☐ Incontinence	☐ Kidney disease
☐ Blood in stool or rectal bleeding	☐ Sexual Dysfunction
☐ Liver disease	☐ Sexually active
☐ Gallbladder disease	*Method of birth control:*

FOR MEN	FOR WOMEN	
☐ Prostate disease	☐ Pregnant or trying to conceive	
Other issues:	*First day of last menstrual period:*	
	☐ Heavy or irregular menstrual bleeding	☐ Hot flashes
	☐ Bleeding between menstrual periods	☐ Vaginal dryness
	☐ Severe cramps	☐ Abnormal pap smear
	PAP smear, date of last exam:	
	Number of pregnancies:	
	Number of term births (39-41 weeks):	
	Number of pre-term births:	
	Abortion or miscarriage:	
	Living children:	

Client #:_____

MUSCULOSKELETAL	SKIN/BREAST
☐ Joint pain or swelling	☐ Skin rash, itching
☐ Back pain	☐ Wound
☐ Arthritis	☐ Change in hair or nails
☐ Fracture or broken bones, *list:*	☐ MRSA infection
☐ Osteoporosis	☐ Breast tenderness or discharge
List assistive devices:	☐ Breast lump
NEUROLOGICAL	
☐ Frequent headaches or migraines	☐ Seizures, *specify type:*
☐ Lightheadedness	*Date last seizure occurred:*
☐ Loss of consciousness	☐ Concussion or TBI, *specify type:*
☐ Disorientation	☐ TIA or stroke, *specify type:*
☐ Memory loss	☐ Numbness or muscle weakness
☐ Problem with walking	
ENDOCRINE	**HEMATOLOGIC/LYMPHATIC**
☐ Heat or cold intolerance	☐ Easy bleeding or bruising
☐ Excessive thirst or appetite	☐ Anemia
☐ Thyroid problems	☐ Other blood disorder, *specify:*
☐ Diabetes	☐ Enlarged lymph nodes
ALLERGIC/IMMUNOLOGIC	
☐ Environmental allergies	☐ Autoimmune disease, *specify:*

B. List any medications and dose currently being prescribed, the prescriber, and the date prescribed:

Medication:	Prescriber	Date:

C. List any surgical procedures and date or age at time of surgery:

Surgeries:	Date:

D. List recent exams, laboratory studies, or imaging:

Exam/Test:	Date:	Result:

E. List any other health concerns:

Concern	Date of Onset:

F. Indicate whether family members have a history of the following medical problems, if deceased list major illness or cause of death, and please also specify whether grandparent(s), aunt(s) or uncle(s) are from your mother's or father's side of the family:

FAMILY MEDICAL HISTORY							
	Age	Heart disease	Stroke	Diabetes	Cancer	Mental illness	Substance abuse
Mother							
Father							
Sibling							
Sibling							
Sibling							
Sibling							
Grandmother (maternal)							
Grandfather (maternal)							
Grandmother (paternal)							
Grandfather (paternal)							
Aunt (maternal)							
Uncle (maternal)							
Aunt (paternal)							
Uncle (paternal)							

LIFESTYLE		
What hobbies or social activities do you enjoy?		
List types of exercise or regular physical activity:		
Number of hours of sleep per night:		
☐ I have difficulty falling asleep	☐ I have difficulty staying asleep	
☐ I take naps during the day, *How often and for how long?*		
☐ I often feel tired, fatigued, or sleepy during the daytime		
☐ Caffeine		
How many servings of coffee, tea, caffeinated soda or energy drinks do you drink daily?		
☐ Nicotine		
Number of cigarettes/pack?	How often?	Age started:
☐ Alcohol		
How many drinks?	How often?	Age started:
☐ Marijuana		
How much?	How often?	Age started:
List any street drugs or non-prescribed medication you have recently used?		
How much?	How often?	Age started:
How much?	How often?	Age started:
How much?	How often?	Age started:
List any street drugs or non-prescribed medication you have tried in the past:		