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CSWFL
COUNSELING OF SOUTHWEST FLORIDA

MEDICAL INFORMATION/HISTORY

Client's name_____Today's date_____

Medical doctor's name_____

Medical doctor's address_____

Medical doctor's phone number_____ Date of last physical exam_____

Medical History (Write yes or no, appropriate response, or check appropriate item)

Allergies_____Penicillin _____Codeine ____Aspirin _____Other medications (Please list)_____

Medications you are taking for physical/medical conditions_____

Medications you are taking for psychiatric conditions_____

Over the counter medications you are taking such as: vitamins, aspirin, and laxatives_____

Surgical operations_____

Hospital admissions for medical conditions_____

Pregnancies ____Total number ___How many are living now ___abortions/miscarriages ___stillbirths

My last menstrual period began on_____ my periods are ____regular _____excessive _____stopped _____PMS

Birth Control _____pill _____spermicidal _____IUD _____abstinent _____surgical _____condom _____none _____other, please list_____

Injuries _____adult _____child Please list_____

Infectious diseases _____adult _____child Complications_____

____gonorrhea ___syphilis ___HIV/AIDS ___Hepatitis please list other_____

Growths _____tumors _____growths _____cancer _____cysts

Alcohol _____yes _____occasionally _____quit _____never complications_____

Drugs _____yes _____occasionally ____quit _____never complications_____

If you use drugs and/or alcohol what effects do they have on your health? _____
_____

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Are you on a special diet? _____yes _____no If yes, what kind? _____

PLEASE CHECK EACH ITEM THAT MIGHT PERTAIN TO YOU

Respiratory System ____cough ____flu ____TB____bronchitis ____emphysema____shortness of breath _____asthma

Heart and Blood Vessels ____angina _____heart attack ____stroke ____swelling ___cannot walk far ___sit up to sleep __nosebleeds __palpitations ___bad veins ___phlebitis _____high blood pressure _____irregular pulse or heart beat

Digestive System ___ulcers ___nausea ___vomiting with or without blood __heartburn __diarrhea ___jaundice _____constipation _____cirrhosis _____stomachaches _____colitis _____bad teeth/gums

Kidney, Bladder, Genitals ___cystitis ___loss of control __burning ___sores ___itching ___discharge ___stones ___bloody urine __P.I.D. __sterility __up at night ___frequency __difficulty starting urination __impotent __concern about sex organs __bed wetting

Bones, Muscles, Joints __arthritis __brittle bones __aches __weakness __deformity __need artificial placement __difficulty bending __difficulty lifting __fractures __skull surgery or fracture __amputation

Nervous System __headaches __dizziness __abnormal movements __vertigo __numbness __paralysis __fainting __seizures __amnesia __confusion __spasms __strange sensations __tremors or shakes __epilepsy

Skin __rash __itch __sores __skin cancer __new or changing mole or lump _____reaction to the sun

Blood __anemic __low white blood count __blood disease __bleed or bruise easily __blood poisoning

Glands, Metabolism __diabetes __abnormal blood sugar __thyroid problem __goiter

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__hormone problems __weight

The Five Senses Difficulty with __seeing __hearing __smelling __tasting __feeling

__I wear or need glasses __I wear or need a hearing aid __I have glaucoma

__I had a glaucoma test __I have never had glaucoma test __cataracts

Family History **(State which relative may have had the following)**

Mental Illness	_____	Hypertension	_____
Mental Retardation	_____	Alcoholism	_____
Epilepsy	_____	Heart Disease	_____
Tuberculosis	_____	Cancer	_____
Drug Abuse	_____	Kidney Disease	_____
Diabetes	_____	Other	_____
Stroke	_____		

Other Medical concerns you feel it is important we know about that weren't discussed in the previous sections

_____
_____
_____

_____ _____

Client Signature **Date**

_____ _____

Parent/Guardian Signature **Date**