_____ CD _____ F/MH

Clinician: _____

Physical Health Inventory

Please complete the following questionnaire completely and accurately. The information you provide will allow us to help you more effectively. This is part of your clinical record and is kept confidential. This form will be reviewed by one of our medical staff who will meet with you to review the information you provide. Feel free to discuss any questions or medical concerns you have when you meet with our medical staff.

Today's Date _____ Patient Name _____ Age _____

Date of Last Physical Exam _____ Height: Ft ____ In____Weight _____ Occupation _____

List all over the counter medications you regularly use, amount taken, and reason for taking:

Med	Dosage	Frequency Taken	Reason for Taking

List all prescription medications you use and amount taken

Med	Dosage	Frequency Taken	What is it Prescribed For?

If there are any medications you have used in the past *that are not listed above* to manage mental health, or emotional, or physical health problems, please identify them below:

Med	Dosage	Last Time Prescribed/used	Was the issue resolved	
			Yes	No

Are you allergic to any medications? If so, please list: _____

_____

Do you have any other allergies that we should be aware of? _____

What happens? _____

Answer yes or no to the following questions. If yes, please explain:

Yes	No		Explanation
		General Constitution	
		Have you had any major illnesses, injuries, surgeries or hospitalizations within the last 10 years?	Please list:
		Are you currently receiving medical treatment from a doctor or hospital for any medical or emotional problem?	For what? By whom?
		Nausea or vomiting	
		Chills or fever	
		Unusual lumps or swelling - If so, where? hands, feet, face, neck, under arms, groin area, other	
		Do you have any concerns regarding the possibility of HIV in infection? (IV drug use or unprotected sex)	
		Would you like information regarding HIV testing or resources for scheduling an appointment for HIV testing?	
		Cancer	
		Thyroid disease	
		Blood disorder	
		Appetite up or down	
		Have you had any weight change in the past year?	If so, how much?
		Obesity or Overweight?	
		Diabetic	
		How many cups of caffeinated coffee per day? Caffeinated tea? Caffeinated soda?	Coffee _____ Tea _____ Soda _____
		Do you use tobacco (smoke or chew)?	Type _____ How much _____ # of years _____
		Would you like information regarding counseling programs or hand-outs to help you stop smoking?	
		Do you have a safe environment to live?	
		Ever used IV needles for recreational drug use	
Yes	**No**		**Explanation**
		Neurological	

		Head trauma/injury If so, when?	How did it happen?
		Epilepsy (seizures/convulsions)	
		Headaches	
Eye			
		Date of last eye exam:	
		Does your vision limit activities of daily living (driving reading, working, etc)	
		Do you wear glasses or contact lenses	
		Any other problems with your eyes (pain, redness, etc)	
Ear/Nose/Throat/Mouth			
		Any trouble hearing? describe:	Date of last hearing exam:
		Nosebleeds	
		Difficulty swallowing	
		Date of last dental exam?	
		Toothache	
		Sores in mouth, tongue or gums	
		Dentures	
GI/GU			
		Problems urinating: frequent or painful urination	
		Kidney disease	
		Change in bowel habits: blood in stools, black or tarry stools	
		Other problems or concerns related to bowels or urination	
Respiratory			
		Tuberculosis (TB)	
		Wheezing/difficulty breathing	
		Persistent cough	
		Coughing up blood	
Heart			
		High Blood Pressure	
		High Cholesterol	
		Chest Pain	
		Heart Attack	
		Stroke	
		Coronary bypass or Vascular Disease or Angioplasty	
		Other Heart problems/diseases	
Hepatic			
		Liver Disease	
		Yellowing of skin or eyes	
		Hepatitis	
Musculoskeletal			
		Trouble with arms or legs	

		Trouble with back or spine	
		Stiff, swollen, or painful joints	
Skin			
		Skin problems	
		Skin Cancer	
		Dark or black moles or birthmarks	
		Varicose Veins	
Mental//Emotional Health and Substance Use			
		Mental/Emotional Disorder	If, yes, are you currently receiving treatment? By whom?
		Do you cope with anxiety or try to control your weight by binge eating, use of laxatives, ipecac, vomiting, etc.?	
		Nervousness/Excessive Worry	
		Anxiety or panic feeling	
		Depression	
		Trouble falling asleep or staying asleep	
		Nightmares	
		Suicidal thoughts	
		Suicidal attempts	When? How?
		Enjoy hobbies, fun, work	
Sexual History			
		Libido (change in sex drive)	
		Any concerns regarding birth control	
		Any concerns regarding sexually transmitted disease	
		Women only:	
		Irregular or painful menstrual or missed periods	
		Vaginal discharge	
		Pap smear in past year	
		Lumps in or discharge from breasts	
		Are you pregnant or think you may be?	If yes, how many months?
		Men only:	
		Penile discharge	
		Testicular lumps	
		Sexual dysfunction	
Other			
		Do you have any other health complaints or concerns that you have not already identified?	If yes, please identify: