

DIRECTIONS: If you are filling this out for a child or adolescent, remember that the questions pertain to the child or adolescent.

Consumer Name _____ Age _____ Height _____ Weight _____

1. FAMILY PHYSICIAN: _____

Date Last Seen by Physician _____ Date of Last Exam _____

In Past Year: Weight Gain _____ Weight Loss _____ Last Blood Pressure _____

2. CURRENT HEALTH: Excellent Good Poor

Last Dental Exam _____ Gum Condition _____ Dentures/Appliances: Upper Lower Other _____

3. IS THERE ANY POSSIBILITY YOU MIGHT BE PREGNANT: Yes No

<p>4. CHILDHOOD DISEASES:</p> <p><input type="checkbox"/> Diphtheria <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Measles <input type="checkbox"/> Small Pox <input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> German Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Scarlet Fever</p> <p><input type="checkbox"/> Parasites <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Other _____</p>	<p>5. PRESENT COMPLAINTS: Indicate if you experience:</p> <p><input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Backache <input type="checkbox"/> Weight Change</p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Chest Pains <input type="checkbox"/> Tiredness <input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Cough <input type="checkbox"/> Breathing Problems</p> <p><input type="checkbox"/> Other _____</p>
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6. IMMUNIZATIONS: (To be completed by parent/guardian for consumer under 18 years of age)

Are your child's immunizations up to date? Yes No If no, please explain: _____

<p>7. HISTORY OF ILLNESSES:</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Heart Disease <input type="checkbox"/> Headaches <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Head Injury</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Back Problems <input type="checkbox"/> Hepatitis <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Ulcers <input type="checkbox"/> Poor Nutrition <input type="checkbox"/> Sexually Transmitted Disease</p> <p><input type="checkbox"/> Seizures <input type="checkbox"/> Skin Diseases <input type="checkbox"/> High Blood Pressure</p>	<p>8. HAVE YOU EVER BEEN TESTED POSITIVE FOR:</p> <p>Hepatitis B: <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____</p> <p>Tuberculosis: <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____</p> <p>HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____</p>
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9. SURGICAL PROCEDURES/ACCIDENTS/HOSPITALIZATIONS (Describe and Date):

10. ALLERGIES: Medication: (List) _____

Foods/Environment: _____

11. ELIMINATION PROBLEMS: Constipation Diarrhea Inability to control bowel/bladder

12. DO YOU HAVE PROBLEMS WITH: Hearing Speech Vision Sleep

Please explain: _____

13. CULTURAL OR RELIGIOUS FOOD CUSTOMS: _____

14. VITAMIN/MINERAL OR FOOD SUPPLEMENT? Yes No

What do you take and how much? _____

15. DO YOU EAT THREE MEALS A DAY? Yes No If not, what do you skip or add? _____

16. OTHER IMPORTANT NUTRITION INFORMATION: (e.g. History of malnutrition problems, appetite change when starting meds, meals eaten at school, etc.) _____

MEDICAL PROFILE

17. WOULD YOU LIKE ADDITIONAL DIETARY TEACHING FROM OTHER SOURCES? Yes No

18. CURRENT MEDICATIONS:

<u>Name/Strength</u>	<u>When Taken</u>	<u>Condition Taken For</u>	<u>Effectiveness and/or Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

19. MEDICATIONS DISCONTINUED DURING PAST SIX MONTHS:

<u>Name/Strength</u>	<u>When Taken</u>	<u>Reason Discontinued</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

20. ALL PREVIOUS PSYCHIATRIC MEDICATION TAKEN:

<u>Name/Strength</u>	<u>Was it helpful?</u>	<u>Problems/Side Effects</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe <input type="checkbox"/> No	_____

21. DRUG AND ALCOHOL HISTORY:

A. Do you consider your present or past use of drugs or alcohol to be a problem? Please explain: _____

B. What tobacco products do you use, if any? _____ How much? _____

C. Have you, anyone in your family, or anyone in your home ever been involved in an alcohol or drug treatment program?

Please explain: _____

D. Does anyone in your home or in your family have an alcohol or drug related problem? Has anyone in the past?

Please explain: _____

22. HAVE YOU EVER BEEN PHYSICALLY OR SEXUALLY ABUSED? Yes No _____

23. ARE THERE OTHER IMPORTANT HEALTH CONCERNS YOU WISH TO DISCUSS WITH US? _____

Consumer Signature or Parent/Guardian Signature

Date

Provider Signature

Date

We recommend that all our consumers have a yearly physical examination.

MEDICAL PROFILE