Rochester Psychological Associates
620 Crosskeys Office Park
Fairport, NY 14450

BRIEF HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

Please list the names of any medical specialists you have seen over the past 5 years:

OB-GYN: _____
PEDIATRICIAN: _____
OTHERS: _____
_____
_____

Please indicate presence of any major medical problems:

	NO	YES		NO	YES
Heart Disease	_____	_____	Head Injury	_____	_____
Hypertension	_____	_____	Seizures/Epilepsy	_____	_____
Asthma/Respiratory	_____	_____	Neurological Disorder	_____	_____
Stomach/GI Problems	_____	_____	HIV+/AIDS	_____	_____
Liver Disease	_____	_____	Visually Impaired	_____	_____
Renal Disease	_____	_____	Hearing Impaired	_____	_____
Cancer	_____	_____	Other: _____		

When was your last physical exam? _____

Please list all medications you take regularly:

Prescribed Medications:

Name	Dose	How often	Prescribed by	Date started

(if you need to list others, please continue at the bottom of the next page)

Over-the-counter Medications, Supplements, Vitamins:

Do you have any drug allergies? NO _____ YES _____

Please list: _____

Do you have any other allergies? NO _____ YES_____

Please list: _____

Have you had any adverse reactions to medication or other substances? NO_____ YES_____

If yes, describe _____

Do you consume products with caffeine? NO _____ YES _____

Describe: _____ How much?_____

Do you use tobacco? NEVER _____ IN PAST/NOT NOW _____ YES _____

How much?_____

Do you drink alcohol? NEVER _____ IN PAST/NOT NOW _____ YES _____

How much? _____

Have you ever had a drinking problem? NO___ YES____ Currently? NO_____ YES _____

Do you use any illegal drugs? NEVER_____ IN PAST/NOT NOW_____ YES _____

Have you ever abused prescription medication (prescribed or not prescribed for you)? NO____ YES____

Currently? NO_____ YES_____

Do you exercise regularly? NO _____ YES _____

How healthy are your eating habits? GOOD_____ FAIR_____ POOR_____

Have you ever had mental health treatment? NO _____ YES_____

Name of Provider/(MD/PhD/CSW/unknown)	When Treated/for how long	Helpful?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had substance abuse treatment? NO_____ YES_____

Name of Provider	When Treated	Helpful?
_____	_____	_____
_____	_____	_____