

**North Central Career Development Center
MEDICAL HISTORY PART A
(information to be furnished by client)**

Name _____ Sex ___ Birth date _____ Occupation _____

Family History

	Living Age	Living Health	Deceased Age at Death	Deceased Cause of Death
Spouse				
Father				
Mother				
Brothers & Sisters				

Is there a family history of:

	Yes	No	Who
Chemical Dependency			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Mental-Emotional Illness			
Physical/Emotional/Sexual Abuse			

Past Medical History

Hospitalizations – purpose and date(s): _____

Serious illnesses or accidents – nature and date(s): _____

Have you consulted a physician within the past five years? Yes ___ No ___ If yes, when and for what treatment? _____

Have you consulted a psychiatrist, psychologist, marriage counselor or other counselor in the past? Yes ___ No ___ If yes, date(s) and reason(s) _____

Personal History

Family relationships:

Spouse, birth date and state of health _____

Children, birth date(s) and state of health _____

Personal Health Habits

Sports and recreations (indicate frequency) _____

Describe the physical fitness program you follow _____

Current medications (name and dosage) _____

Significant side effects of current medications _____

Tobacco, type and how much? _____

Alcohol, type and how much? _____

Daily caffeine intake _____

Drugs for non-medical purposes (type and how much) _____

Sleep pattern _____

Describe any recent weight change: _____ Gained _____ Lost How much? _____

Describe recent change in memory or concentration _____

Do you have any hearing or vision problems? Yes ___ No ___ If yes, please elaborate _____

Do you have any of the following symptoms regularly or severely enough to cause you concern?

	Yes	No		Yes	No
Abdominal pain			Frequent urination		
Alcohol or drug dependency			Headaches		
Allergies			Joint pains		
Ankle swelling			Nausea or vomiting		
Chest pain			Nervousness		
Cough productive of blood			Painful urination		
Cough productive of phlegm			Rapid or irregular heartbeat		
Diarrhea or constipation			Sexual concerns		
Difficulty concentrating			Shortness of breath		
Dizziness			Other health worries		
Fainting spells					

Is there any medical information about you as a male or female that is pertinent to your medical history?

Additional comments _____

Date information furnished _____

