SEVEN HILLS HOSPITAL

Place patient label here
Patient Name: _____
Medical Record #: _____

Client Questionnaire For Medication

Name: _____ DOB #: _____

1. Do you have a family physician? NO YES
   If yes, provide name and contact information: _____

2. What was the date of your last checkup by a physician? _____

3. Do you see any other doctor(s)? NO YES
   If yes, provide name, date of visit, and reason for visit(s):_____
   _____

4. Have you ever been hospitalized for any reason? NO YES
   If yes, provide the date and reason for hospitalization(s): _____
   _____

5. Do you currently have any physical illnesses? NO YES
   If yes, list the illnesses: _____

6. Do you currently take any medications for any reason? If yes, provide the following:

MEDICATION	DOSAGE	REASON TAKEN	DATE PRESCRIBED

7. Are you allergic to any medications? NO YES
   If yes, provide the name of any such medication and any effect on the client:
   _____

8. Have you ever had a negative reaction to a psychiatric medication? NO YES
   If yes, provide the name of the medication(s) and any effect on the client:
   _____

9. If applicable, have you gone through menopause? NO YES

10. If applicable, are you currently attempting to get pregnant? NO YES

11. Please check all health-related issues experienced currently or in the past related to the following:

	NOW	PAST		NOW	PAST
Headaches	____	____	Heart	____	____
Head injury	____	____	Blood pressure	____	____
Seizures	____	____	Diabetes	____	____
Loss of consciousness	____	____	Breathing	____	____
Memory	____	____	Thyroid	____	____
Vision	____	____	Liver	____	____
Rashes	____	____	Stomach	____	____

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	NOW	PAST		NOW	PAST
Infections	____	____	Weight loss	____	____
Bones or joints	____	____	Weight gain	____	____
Anemia	____	____	Constipation	____	____
Urination	____	____	Diarrhea	____	____

12. Please provide any additional information related to your medical history or current medical conditions:

_____

_____ _____

Client Signature (including minors) Date

_____ _____

Legal Guardian Signature (if applicable) Date