MEDICAL CHECKLIST

Client's name _____

Age ☐ Height ☐ Weight ☐

Date of lost physical exam: _____

Any abnormal findings (more space on reverse): _____

Name of family physician: _____

Address: _____

Phone #: _____

Person to be called in the event of emergency: _____

Address and Phone #: _____

List any prescription and non-prescription medications taken currently or in the last 6 months:

Regularly — Side effects

Occasionally — Side effects

Comments on effectiveness of above medication:

Check any of the following which you have had:

Yes	No		When
		Breathing problems	
		Kidney/bladder problems	
		Cancer/tumors	
		Diabetes	
		Headaches	
		Unusual smells or tastes	
		Fits/convulsions	
		Stomach/bowel problems	
		Dizziness/black outs	

Comments: _____

Yes	No		When
		Heart problems/irregular beats	
		High blood pressure	
		Menstrual difficulties	
		Thyroid problems	
		Glaucoma/visual problems	
		Heavy sweats	
		Increased thirst	
		Sudden episodes of violence	
		Other (specify)	
		Other (specify)	

Check any of these habits which you have:

Yes	No		Amount/frequency
		Alcohol	
		Coffee	
		Drugs (specify)	

Comments: _____

Note any allergies you have:

Yes	No	
		Drugs (specify)
		Foods (specify)
		Chemicals (specify)
		Other (specify)

Have you had major surgery? Yes ☐ No ☐ If yes, please describe: _____

Have you had major illnesses, such as encephalitis, hepatitis, syphilis, etc? yes ☐ no ☐
If yes, please describe (more space on reverse): _____

Have you had a head injury with a loss of consciousness? Yes ☐ No ☐ When ☐
Are you pregnant? Yes ☐ No ☐

_____
Name of person filling out form Date