

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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## CLIENT MEDICAL WORKSHEET

1. Medical conditions that run in your family:  Unknown

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2. Psychiatric or addictions Treatment History:  None

WHERE	WHEN	WHY

3. Chronic Illnesses—list any significant current or past medical conditions:  None

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4. Serious Accidents—list any past serious accidents and when they occurred:  None

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5. Surgeries/Operations—list any major surgeries and when they occurred:  None

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6. Infectious Illnesses—list any infectious illness-such as HIV, Hepatitis A, B, or C:  None

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7. Disabilities—please describe disability:  None

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Adaptive Needs—do you require adaptive/assistive equipment?  Yes  No If yes, what type?

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8. Dental Concerns:  None

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9. Pain Issues—is physical pain an element of your current distress?  Yes  No If yes, describe:

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Severity of your pain:  Low  Minimal  Moderate  Severe  Very Severe

Level it impacts daily functioning:  Low  Minimal  Moderate  Severe  Very Severe

10. Current Pain Treatment:  None

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How effective is it?

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11. If you are receiving pain treatment, who is your provider?

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12. Nutritional Concerns—describe any concerns you have about your eating habits:  None

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13. Pregnancies/Deliveries:  None

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14. Smoking status:  Current every day smoker  Current some day smoker  Former smoker  
 Never Smoked  Smoker, current amount unknown  Unknown

15. If a smoker, do you want to quit?  Yes  No

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16. Current Medications:

MEDICATION	DOSE	HOW OFTEN	WHY	PROBLEM/SIDE EFFECT

17. List medications which caused you problems or were ineffective:

\_\_\_\_\_

18. Do you have any allergies?  Yes  No

List any allergies you have to medicines or other substances:

\_\_\_\_\_

FAMILY PHYSICIAN	DENTIST
Name: _____	
Street Address: _____	
City, State, Zip: _____	
Phone: _____	
Date of last exam: _____	

OTHER MEDICAL PROFESSIONAL	OTHER MEDICAL PROFESSIONAL
Name: _____	
Street Address: _____	
City, State, Zip: _____	
Phone: _____	
Date of last exam: _____	
Specialty: _____	

### TUBERCULOSIS SCREENING SECTION

#### SECTION A

- Yes  No Do you have an unexplained, persistent, productive cough that has lasted for 2+ weeks?
- Yes  No Are you coughing up blood?
- Yes  No Have you had recent weight loss not associated with dieting or known cause?
- Yes  No Have you had recent loss of appetite not associated with depression or anxiety or other known condition?
- Yes  No Are you running a fever?
- Yes  No Do you have persistent chills?
- Yes  No Do you have persistent night sweats?
- Yes  No Do you have unexplained chest pains?
- Yes  No Have you seen a physician for any of the items marked yes above?

#### SECTION B

- Yes  No Have you ever been exposed to someone with TB? If yes, when was the exposure?
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- Yes  No If yes, did you receive treatment for TB?
- POS  NEG If yes, and you received a chest x-ray, what were the results?  
When was your last TB skin test?
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- POS  NEG What was the results of the skin test?
- Yes  No Have you ever had a reaction to a TB skin test?
- Yes  No Are you currently homeless?
- Yes  No Are you currently living in a shelter?
- Yes  No Are you aware of anyone with TB who lives in your area?
- Yes  No Have you been in jail at any time over the past six (6) months?  
If yes, how long was your stay in jail?
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- Yes  No If in jail, was a TB skin test done while in jail?
- POS  NEG If yes, what was the result?

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Section C

- Yes  No Have you ever injected illegal drugs?
- Yes  No Are you currently HIV+?
- Yes  No Have you been diagnosed with AIDS?

Revised Thursday, April 12, 2012