COASTAL BEHAVIORAL HEALTHCARE, INC.
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____Date of Birth:_____

Allergies: _____

Primary Care Doctor: _____ Last seen by Doctor:_____

Please be advised that we recommend to our clients annual physicals provided by their personal physicians. Providing us a copy of this medical information may be helpful in serving you more effectively.

MEDICAL CHECKLIST (CHECK IF PROBLEM)

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer/Tumors
- ☐ Cirrhosis
- ☐ Diabetes
- ☐ Emphysema
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Menstrual Problems
- ☐ Recent Unexplained Weight Change
- ☐ Seizures/Epilepsy
- ☐ Sleep Disorder
- ☐ STI's (Sexually Transmitted Infection)
- ☐ Stroke (CVA)
- ☐ Transfusions (history of)
- ☐ Tuberculosis
- ☐ Vision Loss/Changes
- ☐ Other_____

SIGNIFICANT MEDICAL HISTORY:

Hospitalizations _____

Surgeries _____

CURRENT MEDICATIONS: List All Medications (Currently Taking. Continue on back if needed.)

_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Client Signature Date

_____ ID #:_____
Staff Reviewer Signature