Attachment 5

Psychotherapy & Pastoral Counseling Associates

MEDICAL INFORMATION QUESTIONNAIRE

Name _____ Date _____

Primary care physician

_____
Name

_____
Phone FAX

Other physician(s)

_____
Name

_____
Phone FAX

When did you last visit with your doctor? _____
Briefly describe what that was about? _____
_____
_____

Current Medications

Date of Rx:	Physician:	Medication and Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication allergies

_____ _____ _____
_____ _____ _____

Medication Updates

_____
_____
_____ _____ _____

-OVER-

What is the general state of your health? _____
_____
_____

List any regular exercise and/or recreation (indicate frequency) _____
_____
_____

Tobacco -- type? Amount and frequency? _____

Alcohol -- type? Amount and frequency? _____

Recreational drugs -- type? Amount and frequency? _____

Coffee? Amount and frequency? _____

Caffinated cola/soda? Amount and frequency? _____

Have you had any serious illnesses, operations and/or hospitalizations? If yes, please list the type and approximate dates _____

_____

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

	Yes		Yes
Chest pains	_____	Abdominal pain	_____
Shortness of breath	_____	Chronic pain	_____
Ankle swelling	_____	Nausea or vomiting	_____
Rapid or irregular heart beat	_____	Diarrhea or constipation	_____
	_____		
Dizziness	_____	Nervousness	_____
Fainting spells	_____	Confusion	_____
Difficulty concentrating	_____	Allergies	_____
Frequent urination	_____	Sexual concerns	_____
Painful urination	_____	Headaches	_____
Forgetfulness	_____		

Other health worries and additional comments _____

_____

_____

_____