

FAMILY GUIDANCE CENTER OF WARREN COUNTY

SCREENING: NEED FOR PHYSICAL EXAM REFERRAL

Name: _____ Gender: _____ AGE: _____ Height _____ Weight _____

Private Physician's Name: _____ Phone: _____

Physician's Address: _____

MEDICAL HISTORY

(Use Notes area if needed for additional items)

1. **Date of last complete physical exam (with lab report):** _____

Result: _____

2. **If female, date of last gynecological exam:** _____

Result: _____

3. **Date of last dental visit:** _____

4. **What Medications, if any, have been prescribed for you (you may include a separate list if necessary):**

Medication	Dosage

5. **Are you allergic to any medications?** Yes No If yes, please list:

6. **Have you had any of the following? (please check if yes):**

Eye Disease	High Blood Pressure	Prostrate
Heart Disease	Seizure Disorder	Loss of Consciousness/Fainting
Kidney Disease	Diabetes	Alcohol Problem
Liver Disease	Asthma	Drug Problem

7. **Are you experiencing chronic pain?** Yes No

If yes please describe: _____

8. **Do you have frequent headaches, indigestion, bleeding, diarrhea or other bowel problems?** Yes No

If yes, describe: _____

9. **Do you have any other medical problems?** Yes No
 If yes, describe: _____
10. **Do you drink?** Yes No **If yes, describe:** _____
11. **Do you smoke?** Yes No **If yes, how much?:** _____
12. **Do you use recreational drugs?** Yes No **If yes, what kind/how much:** _____
13. **Have you been hospitalized?** Yes No
 If yes, describe: _____
14. **Have you been in a serious accident?** Yes No
 If yes, describe: _____
15. **Have you ever had surgery of any kind?** Yes No
 If yes, describe: _____

I authorize the Family Guidance Center to obtain medical information from my physician. Yes No

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Reviewed by Therapist – Signature _____ Date: _____

Referred to FGC medical staff? Yes No **If yes route to medical staff for review and signature**

Reviewed by Medical Staff – Signature _____ Date: _____

Referred for Physical Exam? Yes No **If yes route to clinician for follow up (clin initial) _____**

Comments: _____
