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	Prostate Disease
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:____

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