WARREN STREET FAMILY COUNSELNG ASSOCIATES, INC.
HEALTH SCREENING FORM

NAME: _____

DATE OF BIRTH: _____ AGE: _____

PRIMARY CARE PROVIDER: _____
Address: _____
_____
Phone Number: _____
Last Physical: _____

ALLERGIES TO MEDICINES: _____

Medicines you are taking now (including birth control pills). Please indicate the amount of medicine you take and how often.

_____

_____

_____

Do you have any major medical illnesses (such as heart disease, diabetes, arthritis, asthma, kidney disease, liver problems, history of cancer or any other medical problem that requires you to see a doctor often or regularly)? _____
_____
_____
_____
_____

Do you have any eating problems? _____
_____

What medicines do you purchase when you go to the store (pain relievers, digestive aids, vitamins, etc.)? _____
_____
_____
_____

Do you have any current health concerns?_____
_____
_____
_____