Jefferson University Physicians
Department of Psychiatry and Human Behavior Outpatient Services
Health Questionnaire

Name: _____ **Date:**_____

Please fill in this entire form. Do not leave any blank spaces. If a question does not apply to you please put N/A in the space. If you have any problems filling out this form please see the front desk staff. Your doctor will review this form with you after you have completed it.

1. Name and contact information for your primary physician:

2. When was your last physical examination? _____
   Overall finding of your last physical examination:

3. Current physical symptoms and concerns:

4. Current use of any medications (excluding psychotropic meds):

5. Are you allergic to anything? _____ Yes _____ No
   Drugs: _____
   Food: _____
   Environmental Agents: _____

6. History of hospitalizations and surgeries:

7. Has your weight changed in the past 3 months? _____ Yes _____ No
   Do you feel that you have a healthy diet? _____ Yes _____ No

8. Occupational or travel-related exposure to toxins, hazardous materials, etc.:

9. Do you have any laboratory tests currently pending? (If yes, please give details)

10. Family history of major medical illnesses (ex. Cardian condition, hypertension, etc.):

REVIEWING PHYSICIAN SIGNATURE: _____ **DATE:** _____