SEACOAST MENTAL HEALTH CENTER, INC.
ADULT MEDICAL SCREENING

Name: _____ Date of Birth: _____ Date: _____

Primary Care Provider: _____ Date of last visit: _____

Practice/location: _____

Dentist: _____ Date of last visit: _____

Other medical specialist: _____ Date of last visit: _____

Other medical specialist: _____ Date of last visit: _____

Other medical specialist: _____ Date of last visit: _____

Pharmacy: _____ Location: _____

Preventative Health Screenings/Immunizations:
Check the box if you have ever had the following screenings/immunizations, add most recent date if known

☐ Mammogram: _____ ☐ Pap test: _____ ☐ Colonoscopy: _____

☐ Tetanus: _____ ☐ Pneumonia: _____ ☐ Shingles: _____

☐ Flu: _____ ☐ Measles: _____ ☐ Chicken Pox: _____

Health Screening: (please check)	**No**	**Yes**	**Comments**
Do you have MEDICATION ALLERGIES?	☐	☐	
Do you have other allergies or sensitivities (food, environmental)?	☐	☐	
Do you smoke cigarettes or use other tobacco products?	Check the category that applies to you: ☐ Never smoked ☐ Former smoker ☐ Current daily smoker (how much?) _____ ☐ Current some days smoker ☐ Other tobacco use (snuff, chew, e-cigarettes, etc.) ☐ Other: (explain) _____		
Do you consume/use caffeine?	☐	☐	
Do you use alcohol or recreational drugs or misuse prescription medication?	☐	☐	
Have you ever had a head injury or lost consciousness?	☐	☐	
Have you ever had surgery?	☐	☐	
Have you been hospitalized for a medical condition?	☐	☐	
Do you use birth control? If yes, what kind?	☐	☐	
Are you pregnant or planning to become pregnant?	☐	☐	

Medications:

List any prescribed medications, over-the-counter medications, vitamins, or dietary supplements you are now taking:

Name	Dose	Frequency	Name	Dose	Frequency

Nutritional screening: (please check)

	No	Yes	if "yes" please explain.
Has a professional recommended that you be on a special diet?	☐	☐	
Do you consider yourself either overweight or underweight?	☐	☐	
Has your weight recently changed?	☐	☐	
Has your appetite recently changed?	☐	☐	

Height: _____ Weight: _____

Medical History: Check the appropriate boxes below. For all yes answers, provide an explanation

	No	Yes	Explanation: Diagnosis, dates, severity, treatment, results, etc.
High blood pressure	☐	☐	
Diabetes (how is it controlled?)	☐	☐	☐ diet/exercise ☐ oral medication ☐ insulin
Chronic pain (arthritis, degenerative disk disease, fibromyalgia, migraine, etc.)	☐	☐	
Digestive problems (GERD, IBS, Crohn's disease, colitis, constipation, diarrhea, ulcers etc.)	☐	☐	
Breathing/lung problems (asthma, COPD, emphysema, bronchitis, etc.)	☐	☐	
Cardiovascular disease (angina, heart attack, stroke, heart failure, irregular heartbeat, PAD, blood clots, etc.)	☐	☐	
Neurological conditions (epilepsy, seizures, headaches, migraines, etc.)	☐	☐	
Autoimmune disorders (rheumatoid arthritis, lupus, celiac disease, multiple sclerosis, etc.)	☐	☐	
Sleep disturbances (apnea, insomnia, fatigue, sleep walking, nightmares, etc.)	☐	☐	

	No	Yes	**Explanation:** Diagnosis, dates, severity, treatment, results, etc.
Kidney disease/urinary tract problem (kidney stones, bladder infections, kidney infections, enlarged prostate, etc.)	☐	☐	
Thyroid disease (hypothyroidism, hyperthyroidism, goiter, nodules, etc.)	☐	☐	
Cancer (specify type)	☐	☐	
OB/GYN (pregnancy, miscarriage, irregular periods, menopause, stress incontinence etc.)	☐	☐	
Infectious disease (tuberculosis, MRSA, HIV/AIDS, sexually transmitted disease, etc.)	☐	☐	
Liver-related illnesses (hepatitis, jaundice, cirrhosis, non-alcoholic fatty liver disease, etc.)	☐	☐	
Visual impairment (glaucoma, macular degeneration, glasses/contacts, etc.)	☐	☐	
Hearing or ear problems (deaf, hard of hearing, ringing in the ears, etc.)	☐	☐	
Dental symptoms, complaints or illnesses (gingivitis, dentures, partials, etc.)	☐	☐	
Environmental concerns (bed bugs, fleas, vermin, unsanitary conditions, etc.)	☐	☐	
Other illnesses or injuries	☐	☐	

Family Medical History:

Please indicate if a parent, or a sibling have or have had any of the following illnesses:

Illness	No	Yes	Who?	Illness	No	Yes	Who?
High blood pressure	☐	☐		Enlarged prostate	☐	☐	
Diabetes	☐	☐		Mental illness	☐	☐	
Glaucoma	☐	☐		Alcoholism/drug dependence	☐	☐	
Ulcers	☐	☐		Tuberculosis	☐	☐	
Lung disease	☐	☐		Heart Disease	☐	☐	
Thyroid disease	☐	☐		Cancer	☐	☐	
Kidney disease	☐	☐		Seizure disorder	☐	☐	
Head injury	☐	☐		Sexually transmitted disease	☐	☐	
Digestive problems (Crohn's disease, Irritable bowel, colitis)	☐	☐		HIV/AIDS	☐	☐	
				Hepatitis	☐	☐	
				Other (specify)_____	☐	☐	

_____ _____

Client Signature **SMHC Clinician Signature**