ESTHER RESIDENCE
27 Thornton Ave. Saco, ME 04072
MEDICAL ASSESSMENT FORM

Client Name _____ SS# _____ Date of Birth: ___/___/___

Case # _____

Medical Screening Questionnaire:

Doctor's Name/ Medical Clinic _____
Doctor's Address _____ Phone _____
City _____ State _____ Zip _____

Date of Last Complete Physical ___/___/___
Date of Last Complete Hearing Exam ___/___/___
Date of Last Complete Dental Exam ___/___/___
Current/Past Dental Issues ___/___/___
Date of Last Complete Eye Exam ___/___/___

Are You Pregnant? ☐ YES ☐ NO
Medical problems that are currently being treated or symptoms that cause concern _____
_____
Past Medical issues: _____
Do you have any nutritional needs or concerns? _____
_____
Allergies? _____

Please list types and amounts of:

	Medication	**Dosage**
Current prescribed medication(s)	_____	_____
	_____	_____
	_____	_____

Are you taking them as prescribed? _____ How are they working? _____
Other non-prescription medications _____
Past medical hospitalizations/accidents _____
_____
Family history of illness and hospitalizations _____
_____

Have you ever been treated for or had any indication of any of the following?

- ☐ Visual Disturbances
- ☐ Dizziness
- ☐ Severe Headaches
- ☐ Diabetes
- ☐ Fainting
- ☐ Stroke
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Shortness of Breath
- ☐ Asthma or Hay Fever
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Disorders of the Eye
- ☐ Disorders of the Throat
- ☐ Rashes
- ☐ Chronic Skin Disorders
- ☐ Arthritis/Gout
- ☐ Exceptional Chest Pain
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Weakness/Paralysis of Limbs
- ☐ Heart Palpitations
- ☐ Frequent/Persistent Nausea
- ☐ Frequent/Persistent Vomiting
- ☐ Vomiting Blood
- ☐ Blood in Stool
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea/Constipation
- ☐ History of Ulcers
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Intestinal Bleeding
- ☐ Colitis
- ☐ Appendicitis
- ☐ Hemorrhoids
- ☐ Increased Urinary Frequency
- ☐ Pain/Burning on Urination
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Urinary Tract Infections
- ☐ Convulsions
- ☐ Seizures
- ☐ Syphilis/ Gonorrhea
- ☐ Herpes
- ☐ Other STD
- ☐ Head Injury

If you have checked any of the above, please explain your current status: _____
_____
_____
_____