Public Health
Prevent. Promote. Protect.
Harford County
Health Department

DIVISION OF BEHAVIORAL HEALTH
MEDICAL REVIEW FORM

CLIENT NAME: _____

CLIENT INFORMATION									
Name of Primary Care Physician:_____ Month and Date of Last Physical: __ __ / __ __ __ __									
Would you like assistance in locating a Physician: Yes / No			Can we contact your previous medical and/or behavioral health provider: Yes / No						
List Medical Diagnoses (if applicable):									
If you received medical treatment over the past 12 months was it for?		Routine		Significant					
Over the last 6 months, have you been seen at the emergency room? Yes / No If yes, how many times:									
Reason:		Substance Use		Psychiatric		Medical			

Please circle yes or no if you have or had any of the following:								
AIDS/HIV	Yes	No	Renal Dialysis	Yes	No	Hepatitis/Jaundice	Yes	No
Diabetes	Yes	No	Tumors or Growths	Yes	No	Rheumatic Fever	Yes	No
Ulcers	Yes	No	Recent Weight Loss	Yes	No	Eye/Vision Problems	Yes	No
Herpes	Yes	No	Scarlet Fever	Yes	No	Kidney Problems	Yes	No
Lung Disease	Yes	No	Stomach/Intestinal Disease	Yes	No	Encopresis (Loss of Bowels)	Yes	No
Chest Pains	Yes	No	Frequent Diarrhea	Yes	No	Excessive Thirst	Yes	No
Shingles	Yes	No	Cancer Treatment	Yes	No	Frequent Headaches	Yes	No
Spina Bifida	Yes	No	Epilepsy or Seizure	Yes	No	High Blood Pressure	Yes	No
Other:	Yes	No	Liver Disease	Yes	No	Bruise Easily	Yes	No
Breathing Problem	Yes	No	Fainting Spells/Dizziness	Yes	No	Neurological Disorder	Yes	No
Low Blood Pressure	Yes	No	Bleeding Problems/Disease	Yes	No	Thyroid Disease	Yes	No
Heart Trouble/Disease	Yes	No	Enuresis or Bed Wetting	Yes	No	Arthritis/Gout/Joint Pain	Yes	No

Women Only:	Are you Pregnant/Trying to get pregnant?	Yes	No	Date of last Menstrual cycle:
	Taking oral contraceptives?	Yes	No	Age of Menopause:

Date of Last TB Test: _____ **Result (Circle):** Positive / Negative

TB RISK ASSESSMENT: Persons with any of the following risk factors should be tested for TB infection					
HIV infection	YES	NO	Signs and symptoms of TB	YES	NO
Organ transplant recipient	YES	NO	Injection drug user	YES	NO
Recent close or prolonged contact with someone with infectious TB disease				YES	NO
Foreign-born person from or recent traveler to high-prevalence area				YES	NO
Chest radiographs with fibrotic changes suggesting inactive or past TB				YES	NO
Resident or employee of high-risk congregate setting (e.g., prison, hospital, homeless shelter)				YES	NO

Medical conditions associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome)	YES	NO

HEALTH ASSESSMENT

Have you ever taken medications for a Mental/Substance Disorder?	Yes	No	Are you on a special diet?	Yes	No
Are you taking any medications for a medical concern?	Yes	No	Do you have any Allergies?	Yes	No
Have you ever been hospitalized or had a major operation/Illness?	Yes	No	Do you where seatbelts?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No	Is there a gun in your home?	Yes	No
Do you have any cultural or religious health concerns or traditions we should be aware of?				Yes	No

If Yes, to one or more above, please explain:

Any Complementary/Alternative Health Approaches: (Exercise, supplements, healing arts, etc.)

HIV RISK ASSESSMENT

Do you wish to be tested for HIV?	Yes	No	Have you had sex without knowing for sure if the person or people you had sex with had HIV?	Yes	No
Have you shared needles to take drugs?	Yes	No	Have you had sex with many partners, or had sex with someone who has had sex with many partners?	Yes	No
Have you ever had unprotected anal, oral, or vaginal sex?	Yes	No	Have you ever been exposed to the blood or other bodily fluids of someone who is HIV+ or has AIDS?	Yes	No
Have you had sex with someone who has used needles to take drugs?	Yes	No	Have you had sex with someone whom you know has HIV or AIDS?	Yes	No
Have you had a disease passed by sex, such as genital herpes/ syphilis?				Yes	No

Additional Comments/Referrals Made:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or client's) health. It is my responsibility to inform HCHD of any changes in medical status. Furthermore, by signing this document, I am authorizing HCHD to contact the local emergency management system and my primary care physician in the event of an emergency.

Signature of Client or Legal Representative: _____Date: _____

Staff Signature: _____ Date: _____

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MEDICATION	DOSAGE	DATES (CURRENT OR PAST)	EFFECT/OUTCOME/RATIONALE	PRESCRIBING PHYSICIAN

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