



HEALTH ASSESSMENT QUESTIONNAIRE

NOTE ▶ This questionnaire will be used by Vocational Rehabilitation to assess your current health and to evaluate the need for further medical information.

PART I: IDENTIFICATION INFORMATION

Last Name	First Name	M.I.
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What is your disability?

In your own words, how does your disability interfere with you getting or holding a job?

PART II: CURRENT MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN

Name of Doctor	Date of Last Visit
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Address	Reason
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Dates of Treatment	Telephone
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Are you **Currently** receiving treatment for any physical or mental problem? Yes No If yes, provide a brief description, including any medications.

LIST ALL MEDICAL PROFESSIONALS FAMILIAR WITH YOUR DISABILITY

Name of Doctor(s)	Name of Doctor(s)
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Address	Address
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Dates of Treatment	Telephone	Dates of Treatment	Telephone
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LIST ANY HOSPITALS WHERE YOU HAVE RECEIVED TREATMENT FOR YOUR DISABILITY

Name of Hospital (Most recent hospitalization)	Name of Hospital
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Address	Address
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Dates of Treatment	Dates of Treatment
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(ATTACH ADDITIONAL SHEETS IF NEEDED)

PART III REPORTED MEDICAL HISTORY

DURING THE PAST TWO YEARS, HAVE YOU RECEIVED TREATMENT FOR ANY OF THE FOLLOWING AREAS:

- A. **ENT:** eyes, ears, nose, throat, hearing impairments YES NO
 - B. **Neurological:** frequent headaches, dizziness, stroke, epilepsy, seizure disorder, traumatic brain injury, cerebral palsy, paralysis YES NO
 - C. **Respiratory:** breathing, chest/lungs, chronic cough, shortness of breath, emphysema, asthma YES NO
 - D. **Cardiovascular:** heart, blood vessels, rheumatic fever, murmur, palpitation, chest pains, high blood pressure..... YES NO
 - E. **Internal:** stomach, chronic indigestion, ulcers, colitis, gallbladder, liver, kidney, bladder, prostate, genitourinary YES NO
 - F. **Endocrine:** diabetes, thyroid YES NO
 - G. **Orthopedic:** neuritis, arthritis, gout, amputation, any disorder of the muscles, bones or joints YES NO
 - H. **Oncology:** cancer, tumor, cyst, or any other disorder of the skin or lymph glands YES NO
 - I. **Psychiatric:** depression, schizophrenia, bipolar, ADHD or other emotional disorder YES NO
 - J. **Cognitive:** developmental, learning, autism spectrum disorders YES NO
 - K. **Vision Impairments:** diabetic retinopathy, cataracts, glaucoma, retinitis YES NO
 - L. **Infectious Diseases:** hepatitis, tuberculosis, HIV/AIDS YES NO
 - M. **Substance Abuse:** alcoholism, drugs YES NO
 - N. **Other:** had, or been advised to have, any surgical procedures, hospitalizations, medical examinations or consultations not already mentioned YES NO
- Consulted a physician, psychiatrist, psychologist or other practitioner for any reason not mentioned above YES NO

If the answer is yes to any of the above, provide a brief explanation. Include name and address of the doctor(s) and hospital(s).

Please list (describe) any other disability(ies) not listed above, such as spina bifida, sickle cell, anemia, dyslexia, etc.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature (If under 18, parent or guardian must sign)	Date	Parent or Guardian Signature	Date