Brief Medical History – Part 2 of Application Form for Fairview Housing

Please complete this form and fax to Admissions, along with completed application. If needing to email, and in order to protect your private personal information – contact an Admissions Specialist to properly secure your information. Be advised – never just email documents containing your personal confidential information.

Allergies: Please indicate the drugs that you are allergic to and what happens when you take it.

☐ I have no drug allergies that I am aware of.

Drug	What happens?	Drug	What happens?

Please indicate any other allergies you may have:

☐ Bee stings ☐ Hay fever ☐ Pollen ☐ Grass ☐ Animals ☐ Other: _____

Medications:

Please list all medications that you are currently taking; prescribed + over the counter, dose, and how often taken.

Overall Health:

How do you consider your overall health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Specific Past Medical History/Review of Systems

Under the following categories are lists of symptoms, problems, or diagnosis that can occur in anybody. Please check any of these that you currently have or may have had in the past.

Infectious Diseases

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Measles ☐ Mumps

☐ Rubella ☐ Syphilis ☐ Chlamydia ☐ Gonorrhea

Infectious Disease Testing; have you been tested for:

☐ Hepatitis C ☐ HIV ☐ TB

Physical Trauma:

☐ Head trauma ☐ Brain injury ☐ Motor vehicle accident(s)

☐ Broken bones ☐ Broken neck ☐ Broken back ☐ Missing Limbs

General:

☐ Night fever/chills ☐ General weakness ☐ General fatigue ☐ Lupus

☐ Frequent nausea ☐ Change in appetite ☐ Unexplained weight gain/loss

Integument:

☐ Skin cancer ☐ Skin rash ☐ Hair changes ☐ Easy bleeding

☐ Change in skin appearance ☐ Abscesses ☐ Sores

If you have had an abscess(es), was it because of using a needle? ☐ Yes ☐ No

If you now have or have had skin sores, was it from meth use? ☐ Yes ☐ No

Head/Ears/Eyes/Nose/Throat:

☐ Bad teeth ☐ Gum disease ☐ Nasal discharge ☐ Nasal bleeding

☐ Sinusitis ☐ Hearing loss ☐ Mouth sores ☐ Sore throat

☐ Change in vision ☐ Eye discharge ☐ Blindless/Glaucoma

If you have, or used to have, any of the problems above, was it from drug use? ☐ Yes ☐ No

Cardiovascular:

☐ Infection in your heart (endocarditis) ☐ Infection in your heart valve

☐ Heart surgery ☐ Infection in your blood

If you have, or used to have, any of the problems above, was it from drug use? Yes ☐ No ☐

☐ Heart attack ☐ Cardiac arrest ☐ High blood pressure ☐ Angina chest pain

☐ Heart failure ☐ Skipped beats ☐ Palpitations ☐ Arrhythmia

☐ Heart murmur ☐ Rheumatic fever

Respiratory:

☐ Bronchitis ☐ Asthma/Wheezing ☐ Emphysema ☐ Pneumonia ☐ COPD

☐ Tuberculosis ☐ Chronic cough ☐ Lung cancer ☐ SOB ☐ On Oxygen

Psychiatric:

☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia

☐ ADHD ☐ Hallucinations ☐ Thoughts of suicide ☐ Personality disorder

☐ PTSD ☐ Panic attacks ☐ Can't sleep ☐ Sleep terrors

Nervous System:

☐ Chronic Headache ☐ Migraines ☐ Tension headaches ☐ Memory problems

☐ Fainting ☐ Blackout spells ☐ Numbness ☐ Weakness

☐ Paralysis ☐ Alzheimer's ☐ Meningitis/Infection ☐ Multiple sclerosis

☐ Epilepsy ☐ Seizures ☐ Stroke ☐ Mini-stroke

Gastrointestinal:

☐ Hepatitis ☐ Liver disease ☐ Jaundice/Yellow ☐ Ulcers

☐ Hernia ☐ Chronic Reflux ☐ Constipation ☐ Chronic Diarrhea

☐ Blood in stools ☐ Irritable bowel ☐ Crohn's disease ☐ Ulcerative colitis

☐ Loss of bowel control ☐ Gallbladder disease

Endocrine:

☐ Diabetes, Type 1 ☐ Diabetes, Type 2 ☐ Thyroid disease, high ☐ Thyroid disease, low

☐ Pancreatitis

Musculoskeletal:

Spinal Problem:

☐ Bulging Discs ☐ Herniated Discs ☐ Degenerating Discs ☐ Scoliosis

☐ Fibromyalgia ☐ Arthritis ☐ Rheumatoid ☐ Degenerating Bones

Genito-Urinary:

☐ Kidney stones ☐ Kidney infection ☐ Kidney disease ☐ Bladder infection

☐ Kidney failure ☐ Low Kidney function ☐ Dialysis ☐ Loss of control

Hematology:

☐ Easy Bruising ☐ Blood clots ☐ Abnormal clotting ☐ Taking blood thinners

☐ Easy Bleeding ☐ Anemia ☐ Hemophilia ☐ Person

☐ Sickle Cell Trait ☐ Sickle Cell Disease ☐ Swollen glands or lymph nodes

Chronic Pain:

Do you have daily pain? ☐ Yes ☐ No

Do you have chronic back pain (requiring injections/nerve blocks)? ☐ Yes ☐ No

Does your pain make it difficult to perform your activities of daily living? ☐ Yes ☐ No

Do you have daily pain that you feel needs to be treated? ☐ Yes ☐ No

If you have **chronic pain**, please list the cause(s):

_____

_____

_____

Other medical problems (not listed above):

_____

_____

_____

_____

Past Surgical History:

Please list any surgeries you may have had in the past along with the approximate date of the surgery.

_____

_____

_____

Do you have any **Auto Immune Diseases**? If so, please explain.

_____

_____

_____

Do you have any **Mobility Issues**? Any need for **Adaptive Equipment**? If so, please explain.

_____

_____

Questions? To speak with an Admissions Specialist:

Bristol, VA - Men's Program: (276) 821-8030

Abingdon, VA - Women's Program: (276) 451-3996

Business Hours: 8:30 am-4:30 pm EST, Monday-Friday

PLEASE FAX COMPLETED FORM, ALONG WITH CURRENT MEDICAL RECORDS (including Mental Health Records) AND APPLICATION TO:

Bristol Lifestyle Recovery Fax: 423-900-2435

Mended Women Lifestyle Recovery Fax: 276-451-7626