Medical Questionnaire

OTHER MEDICAL CONDITIONS

Description: Any and all significant diseases and disorders for which there is not a specific Questionnaire.

Age of client: _____

Name of medical condition(s): _____

Date of diagnosis: _____

Type of treatment/ medications: _____

_____

_____

Have you ever had surgery for this condition: ☐ Yes ☐ No

If yes,

When: _____

Type of surgery: _____

Results of surgery: _____

Any advised procedures or testing not yet completed: _____

_____

Test results related to this condition if known: _____

_____

_____

Current status of this condition: _____

_____