WISCONSIN SCHOOL OF PROFESSIONAL PSYCHOLOGY
PSYCHOLOGY CENTER

MEDICAL SCREENING FORM

Date: ____________________

Client Name: ________________________________ DOB: ____________________

Current Medical Problem(s):

Current Medication(s): Prescribed by Dr. ____________________

Past Health Problems:

Past Medication(s): Prescribed by Dr. ____________________

Date of Last Physician Visit: ____

Name of Current Physician: ____

DO YOU HAVE:

___ Heart Disease
___ Diabetes
___ Cancer
___ Seizures
___ Stroke
___ Tuberculosis

___ Headaches
___ Chest Pains
___ Shortness of Breath
___ Stomach Problems
___ Dietary Restriction
___ Activity Restriction

___ Allergy ____

___ Disability ____

___ Other infectious disease ________________________________

___ Other ____