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Brief Health Information Form

A. Identification

Name: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List all medications or drugs you take or have taken in the last year-prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Medical Providers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

D. Health habits

1. What kinds of physical exercise do you get? _____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____

3. Do you try to restrict your eating in any way? How? Why? _____

4. Do you have any problems getting enough sleep? _____

5. How much alcohol do you drink each day? Is this a matter of concern to you or of any of your family members?
Do you use any other substances? _____

6. Please identify any food supplements or homeopathic remedies that you use regularly:

