SOCIAL SERVICES AGENCY OF ALAMEDA COUNTY
GENERAL ASSISTANCE PROGRAM - HEALTH QUESTIONNAIRE

Name of the client _____ Date of birth: ___/__/__
Social Security No.____/____/_____ Male _____ Female _____
Case # _____ Worker # _____

	Yes	No
Can you work?		

If the answer is "NO", explain why:

CLINICAL HISTORY: Do you have or have you ever had any of the following problems:

	Yes	No
CARDIOVASCULAR		
1 Enlarged heart		
2 Heart problems or heart attacks		
3 High or low blood pressure		
4 Pain or pressure in the chest		
5 Palpitations or pounding of the heart		
6 Rheumatic fever		
7 Heart murmur		
8 Swelling of feet or ankles		
9 Varicose veins		
10 Fainting spells		
11 Abnormal blood test or EKG		
RESPIRATORY		
12 Asthma or wheezing		
13 Shortness of breath		
14 Chronic cough /hoarseness		
15 Emphysema		
16 Coughed up blood		
17 Abnormal chest x-ray or TB skin test		
GASTROINTESTINAL		
18 Jaundice, hepatitis or cirrhosis		
19 Piles or rectal bleeding		
20 Stomach, liver or intestinal trouble		
21 Ulcers		
MUSCULO-SKELETAL		
22 Fractured/broken bones		
23 Arthritis or rheumatism		
24 Back surgery		
25 Bone, joint, or other deformity of the back		
26 Treatment for back strain or pain		
27 Leg cramps		
28 Painful or trick knee, shoulder, elbow		
29 Rupture or hernia		
30 Spinal curvature, scoliosis		
31 Swollen or painful joints		
32 Worn brace for back support		
33 Worn neck brace or collar		

	Yes	No
NEUROLOGICAL		
34 Balance problems		
35 Epilepsy, convulsions or seizures		
36 Frequent or serious headaches		
37 Head injuries or loss of consciousness		
38 Loss of memory or amnesia		
39 Difficulty in concentration or following instructions?		
40 Paralysis, numbness		
VISION AND HEARING		
41 Color blindness		
42 Double or blurred vision		
43 Glaucoma, cataracts, other eye trouble		
44 Artificial eye		
45 Corrective ocular surgery		
46 Hearing loss		
47 Hearing aid		
MISCELLANEOUS		
48 Drinks alcohol: number of drinks a day _____		
49 Drug or narcotic use		
50 In treatment for drug or alcohol abuse		
51 Attempted suicide		
52 Suicidal thoughts		
53 Disabled, hospitalized, or treated for emotional or mental disorders?		
54 Depression		
55 Frequent trouble sleeping		
56 Nervous trouble of any sort		
57 Used tranquilizers		
58 Smokes: Number of packages a day; _____ Number of years you have smoked: _____		
59 Recent weight gain or loss		
60 Skin condition or rash		
61 Severe tooth or gum trouble		
62 Are you seeing a doctor?		

Name: _____
GIVE DETAILS OF "YES" ANSWERS ABOVE (list by number):

	Yes	No
ALLERGIC		
63 Any allergy (inc. medication, food)		
64 Hay fever		
ENDOCRINE – HEMATOLOGICAL		
65 Sickle Cell Anemia		
66 Diabetes		
67 Goiter or thyroid trouble		
68 Sugar in urine		
ABNORMAL GROWTH		
69 Cancer		
70 Chemotherapy		
71 Cobalt or other radiation treatment		
72 Cyst or tumor		
GENITAL or URINARY		
73 Renal disease		
74 Bladder tumor or problems		
75 Blood in the urine		
GYNECOLOGICAL (Women only)		
76 Are you now pregnant?		
77 Did you, or do you, have any disease or disorder of the female organs?		
ADDITIONAL HISTORY		
78 Have you ever had a disabling or disease?		
79 Are you currently taking medication?		
80 Has a medical provider advised you to have any surgeries?		
81 Is there anything about your health that is bothering you now?		
82 Were you ever hospitalized? (Medical, surgical, psychiatric problems)		
83 Have you filed any law suits or claimed damages because of injury that affects your health?		
84 Have you ever received or applied plan to apply for pension or compensation for disability?		
85 Have you ever been:		
Tested HIV positive?		
Diagnosed for syphilis?		
Recently had a persistent cough?		
Had dark urine, or yellow eyes or skin?		
Had a prolonged episode of diarrhea recently?		

	Yes	No
WORK HEALTH HISTORY		
86 Have you ever filed a claim for a work injury, disease or accident?		
87 Were you ever exposed regularly to substances which irritated your skin?		
88 Have you ever held a dusty job such as sandblasting, or working with materials such as asbestos or silica?		
89 Have you ever held a job that required regular use or contact with chemicals?		
90 Have you ever been unable to hold a job, or denied employment because of:		
Sensitivity to chemicals, dust, sunlight, etc.?		
Inability to perform certain motions?		
Inability to assume certain positions?		
A painful or previously injured back?		
Other medical reasons?		
91 Was your work ever limited or restricted because of health?		
92 Have you lost time from work because of an illness or injury in the last 5 years?		

FAMILY HEALTH HISTORY

93 Have any blood relatives ever had:

List relationship. (Parents,brothers, sisters, children)		Yes	No
Diabetes			
Cancer			
Tuberculosis			
Heart Disease			
Glaucoma			
High blood pressure			

TUBERCULOSIS (TB) TEST:

94. Last chest x-ray
Date: _____
Results: _____

Last TB skin test:
Date: _____
Results: _____

GIVE DETAILS OF "YES" ANSWERS ABOVE (list by number):

_____

_____

I hereby authorize the release of requested information from my record for the use of the Alameda County Social Services Agency.

_____
Signature Date