Ohio | Opportunities for Ohioans with Disabilities

HEALTH ASSESSMENT QUESTIONNAIRE

PART 1. IDENTIFICATION INFORMATION

Last Name	First Name	M.I.
What is your disability?		
In your own words, how does your disability interfere with you getting or holding a job?		

PART II. CURRENT MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN

Name of Doctor		Date of Last Visit
Address		Reason
Dates of Treatment	Telephone	

Are you **Currently** receiving treatment for any physical or mental problem? ☐ Yes ☐ No If yes, provide a brief description, including any medications.

LIST ALL MEDICAL PROFESSIONALS FAMILIAR WITH YOUR DISABILITY

Name of Doctor(s)		Name of Doctor(s)	
Address		Address	
Dates of Treatment	Telephone	Dates of Treatment	Telephone

LIST ANY HOSPITALS WHERE YOU HAVE RECEIVED TREATMENT FOR YOUR DISABILITY

Name of Hospital (Most recent hospitalization)	Name of Hospital
Address	Address
Dates of Treatment	Dates of Treatment

(ATTACH ADDITIONAL SHEETS IF NEEDED)

PART III. REPORTED MEDICAL HISTORY

DURING THE **PAST TWO YEARS**, HAVE YOU **RECEIVED TREATMENT** FOR ANY OF THE FOLLOWING AREAS:

A. **ENT: e**yes, ears, nose, throat, hearing impairments ☐ YES ☐ NO

B. **Neurological:** frequent headaches, dizziness, stroke, epilepsy, seizure disorder, traumatic brain injury, cerebral palsy, paralysis ☐ YES ☐ NO

C. **Respiratory:** breathing, chest/lungs, chronic cough, shortness of breath, emphysema, asthma ☐ YES ☐ NO

D. **Cardiovascular:** heart, blood vessels, rheumatic fever, murmur, palpitation, chest pains, high blood pressure ☐ YES ☐ NO

E. **Internal:** stomach, chronic indigestion, ulcers, colitis, gallbladder, liver, kidney, bladder, prostate, genitourinary ☐ YES ☐ NO

F. **Endocrine:** diabetes, thyroid ☐ YES ☐ NO

G. **Orthopedic:** neuritis, arthritis, gout, amputation, any disorder of the muscles, bones or joints ☐ YES ☐ NO

H. **Oncology:** cancer, tumor, cyst, or any other disorder of the skin or lymph glands ☐ YES ☐ NO

I. **Psychiatric:** depression, schizophrenia, bipolar, ADHD or other emotional disorder ☐ YES ☐ NO

J. **Cognitive:** developmental, learning, autism spectrum disorders ☐ YES ☐ NO

K. **Vision Impairments:** diabetic retinopathy, cataracts, glaucoma, retinitis ☐ YES ☐ NO

L. **Infectious Diseases:** hepatitis, tuberculosis, HIV/AIDS ☐ YES ☐ NO

M. **Substance Abuse:** alcoholism, drugs ☐ YES ☐ NO

N. **Other:** had, or been advised to have, any surgical procedures, hospitalizations, medical examinations or consultations not already mentioned ☐ YES ☐ NO

Consulted a physician, psychiatrist, psychologist or other practitioner for any reason not mentioned above ☐ YES ☐ NO

If the answer is yes to any of the above, provide a brief explanation. Include name and address of the doctor(s) and hospital(s).

Please list (describe) any other disability(ies) not listed above, such as spina bifida, sickle cell, anemia, dyslexia, etc.

TO HELP US PROCESS YOUR APPLICATION FOR SERVICES, PLEASE PROVIDE YOUR COUNSELOR WITH COPIES OF ANY HEALTH INFORMATION THAT YOU MAY HAVE IN YOUR POSSESSION.