



**HEALTH CHECKLIST
FOR EMERGENCY/TEMPORARY CARE**

Name _____ Date _____
Facility _____ Interviewer _____

1. Are you having any health problems at the present time? Yes _____ No _____
Describe _____

2. Have you had any of the following problems in the past 24 hours?
YES NO YES NO YES NO

Sore Throat			Nausea/Vomiting			Diarrhea		
Earache			Headache			Abdominal Pain		
Swollen Glands			Skin Rash			Kidney/Urinary		
Fever/Chills			Drug Reaction					

3. Do you have any medical problems such as:
YES NO YES NO YES NO

Heart Problems			Diabetes			Seizures/Convulsions		
Physical Disability			Asthma			Other		

If other please explain _____

4. Do you think you have an infectious/communicable disease such as:
YES NO YES NO

Hepatitis/Liver Problem			Sexually Transmitted Disease (STD/VD)		
Mononucleosis			Other		

Please explain _____

5. Why do you think this? _____

6. Do you think you have been exposed to any communicable disease in the past 2-3 weeks? Yes _____ No _____
Why do you think this?

7. Are you taking any kind of medication or shots? Yes _____ No _____
If Yes, What kind? What for? _____
Name/Address of physician who ordered it _____

8. Are you allergic to anything like aspirin, foods, medicine, etc?
Specify _____
What happens? _____

9. For girls only: Do you take birth control pills? Yes _____ No _____
If yes, when did you take your last pill? _____

