STATE OF CALIFORNIA — DEPARTMENT OF REHABILITATION

HEALTH QUESTIONNAIRE

DR 218 (Rev. 07/12)

Date

Applicant's Name	Social Security Number	Insurance Coverage
	XXX - XX - XXXX	Medi-Cal# _____
Sex ☐ Male ☐ Female	Height / Weight	Medicare# _____
		Other: _____ # _____

I. APPLICATION REVIEW - Disability(ies) and functional limitation(s) reported on application: _____

II. REVIEW OF CURRENT HEALTH STATUS - Please explain any YES answer in COMMENTS section below.

BODY SYSTEMS - Are you now receiving or have you ever received medical treatment for:

	NO	YES	WHEN
1. Ear(s)/Hearing Problem			
2. Eye(s)/Visual Problem			
3. Mental/Emotional Problem			
4. Nervous Problem			
5. Lung/Respiratory Problem			
6. Heart/Circulation Problem			
7. Digestive Problem			
8. Kidney/Bladder Problem			
9. Legs/Feet/Arms/Hands Problem			
10. Back Problem			
11. Thyroid			
12. Diabetes			
13. Skin Problem			
14. High Blood Pressure			
15. Joint Problem			
16. Arthritis/Rheumatism			
17. Suppressed Immune System			
18. Other (Specify)			

FUNCTIONAL LIMITATIONS - Is your activity or ability to work currently limited by:

	NO	YES
19. Your Hearing		
20. Your Vision		
21. Your Ability to Learn/Read		
22. Your Ability to Speak		
23. Problem Breathing/Coughing		
24. Dizziness/Fainting		
25. Emotional Problems		
26. Weakness (State Where)		
27. Numbness (State Where)		
28. Pain (State Where)		
29. Your Memory		
30. Your Ability to Concentrate		
31. Spells of Unconsciousness		
32. Seizures		
33. Problem Balancing		
34. Problem Walking		
35. Problem Using Hands/Arms/Legs (Specify)		
36. Problem Lifting		
37. Problem Bending		
38. Problem Standing		
39. Problem Climbing		
40. Problem Crawling		
41. Problem Kneeling		
42. Problem Sitting		
43. Difficulty with Driving		
44. Other (Specify)		

COMMENTS:
Explain any YES answers in the space below.
Please indicate the specific item number to which you are referring, the specific problem(s)/area(s) affected, and, if undergoing treatment, the name and address of the provider, if other than listed in Sections E, F, or G on the reverse.
Attach additional sheets if necessary.

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III. ADDITIONAL MEDICAL DATA - If not applicable, indicate N/A

A. Indicate if you now or in the past have smoked, abused alcohol, or used drugs (illegal or abused legal). State specifics, including what, amounts, and when:

_____

B. Do you have allergies? ☐ No ☐ Yes If yes, list: _____

Does this create an interference with your ability to work? ☐ No ☐ Yes If yes, how: _____

_____

C. MEDICATIONS - List medicines you are now taking: _____

_____

Do any of these medications interfere with your ability to work? ☐ No ☐ Yes If yes, explain: _____

_____

D. Have you had any operations or broken bones? ☐ No ☐ Yes If yes, provide specifics and dates: _____

_____

Are there residuals which interfere with your ability to work? ☐ No ☐ Yes If yes, explain: _____

_____

E. DOCTORS/HOSPITALS - From whom/where you have received major medical treatment in the past 2 years:

Name	Address (including zip code)	Phone	Date Last Seen	Nature of Treatment

F. CURRENT EXAMINATION - Have you had a physical/general medical examination in the past 12 months? ☐ No ☐ Yes

If yes, by whom (include address, zip code, and phone number): _____

_____

G. FAMILY PHYSICIAN

Name	Address (including zip code)	Phone	Date Last Seen	Nature of Treatment

IV. SUMMARY - List medical & emotional problem(s) you <u>now</u> have which interfere(s) with your ability to obtain/maintain employment:

PROBLEM	HOW DOES THE PROBLEM INTERFERE?

V. *This information is true and correct to the best of my knowledge. I have reviewed this information with the counselor and approve the inclusion of this information* ***(including any self-disclosure regarding the results of HIV serology testing or suppressed immune system)*** *in my case file with the Department of Rehabilitation.*

Applicant's Signature

VI. *I have reviewed this information with the applicant. All "YES" answers are explained/clarified on this form or attachments.*

Counselor's Signature