STATE OF CALIFORNIA

DEPARTMENT OF REHABILITATION

HEALTH QUESTIONNAIRE

DR 218 (Rev. 04/03)

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

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)	☐	☐	

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.

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)	☐	☐

(OVER)

Attach additional sheets if necessary

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 now 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

(OVER)