Iowa Department for the Blind

Health Assessment

Name: Date:

Date of Birth: Height: Weight:

A. Do you currently have difficulty with:

1. Hearing? Yes ☐ No ☐
2. Seeing? Yes ☐ No ☐
3. Speaking? Yes ☐ No ☐
4. Fainting? Yes ☐ No ☐
5. Seizures? Yes ☐ No ☐
6. Chest Pain? Yes ☐ No ☐
7. Shortness of Breath? Yes ☐ No ☐
8. Chronic Cough? Yes ☐ No ☐
9. Digestion? Yes ☐ No ☐
10. Gynecological Problems? Yes ☐ No ☐
11. Swelling of Hands or Feet? Yes ☐ No ☐
    Which?
12. Weakness / Pain in Hands or Arms? Yes ☐ No ☐
    Which?
13. Weakness / Pain in Legs or Feet? Yes ☐ No ☐
    Which?
14. Numbness? Yes ☐ No ☐
15. Skin Problems? Yes ☐ No ☐
16. Lifting or Bending? Yes ☐ No ☐
17. Climbing (Stairs)? Yes ☐ No ☐
18. Balancing? Yes ☐ No ☐
19. Stand/walk/run Yes ☐ No ☐
20. Kneeling? Yes ☐ No ☐
21. Sitting? Yes ☐ No ☐
22. Learning? Yes ☐ No ☐
23. Reading? Yes ☐ No ☐
24. Concentrating? Yes ☐ No ☐
25. Remembering? Yes ☐ No ☐
26. Get Along w/ Others Yes ☐ No ☐
27. Nervousness (Panic / Anxiety)? Yes ☐ No ☐
28. Depression? Yes ☐ No ☐
29. Stress Tolerance? Yes ☐ No ☐
30. Sleep? Yes ☐ No ☐
31. Energy / Stamina? Yes ☐ No ☐
32. Hallucinations / Delusions? Yes ☐ No ☐
33. Have you ever been unconscious? Yes ☐ No ☐
34. Other:

B. Have you ever had, or been told you have:

1. High Blood Pressure? Yes ☐ No ☐
2. Heart Trouble? Yes ☐ No ☐
3. Developmental Disability? Yes ☐ No ☐
4. Asthma or Lung Disease? Yes ☐ No ☐
5. Tuberculosis? Yes ☐ No ☐
6. Gastrointestinal Problems? Yes ☐ No ☐
7. Psychiatric/Emotional Disorder? Yes ☐ No ☐
8. Eating Disorder Yes ☐ No ☐
9. Kidney or Urinary Trouble? Yes ☐ No ☐
10. Arthritis? Yes ☐ No ☐
11. Diabetes? Yes ☐ No ☐
12. Cancer? Yes ☐ No ☐
13. Other:

C. How much do you use:

Tobacco: Alcohol: Other Drugs:

Do you have a history of dependency on drugs:

If so, please identify your drug(s) of choice:

If so, what is the date of your sobriety?
How often do you attend AA, NA, or other program?

D. Have you been treated for any injuries or conditions?

If Yes, list injury/condition/surgery and resulting limitations:

E. Are you currently taking any medications? (Please mention both prescription and non-prescription or over-the-counter drugs.)

If Yes, list medicines (dosage) and purpose (for what condition)

F. Do you use a cane, brace, wheelchair, hearing aid, or other assistive device?

If Yes, please specify:

G. Pysicians, clinics, & therapists most familiar with your health

Please provide name, address, and date of treatment:

H. Hospitals, Treatment or Rehabilitation Programs where you were an in-patient:

Please provide dates, name, and address:

I. Please summarize the most important problem that interferes with you usual type of work. How long have you been bothered and is the problem getting worse or better?

Date: Signature of Applicant:

Date: Signature of IDB Counselor: