Medical History Screening Form

Please circle YES or NO

Have you or any family member been told you have...

	Self	Family
*Cancer?	Yes..No	Yes...No
*Diabetes?	Yes..No	Yes...No
*High Blood Pressure?	Yes..No	Yes...No
*Heart Disease?	Yes..No	Yes...No
Angina/Chest Pain?	Yes..No	Yes...No
Stroke?	Yes..No	Yes...No
*Osteoporosis?	Yes..No	Yes...No
*Rheumatoid Arthritis?	Yes..No	Yes...No
*Blood Clotting Disorder?	Yes..No	Yes...No
*Connective Tissue Disease?	Yes..No	Yes...No
*High Cholesterol?	Yes..No	Yes...No

Have you recently experienced:

Changes in skin color?..Yes...........No
A loss in your health?...Yes...........No
Head/neck/dental surgery?...................................Yes...........No
A loss of strength/energy due to illness?.............Yes...........No
Nausea/Vomiting/Diarrhea?..................................Yes...........No
*Fever/Chills?...Yes...........No
Unexplained weight loss or gain?........................Yes...........No
Numbness/Pins/Needles?....................................Yes...........No
Changes in appetite?...Yes...........No
*Difficulty swallowing?..Yes...........No
Changes in bowel or bladder function?................Yes...........No
*Loss of bowel or bladder control?.......................Yes...........No
Menstrual irregularities?.......................................Yes...........No
Shortness of breath?..Yes...........No
Dizziness/Lightheadedness?...............................Yes...........No
Upper respiratory infection?.................................Yes...........No
Urinary tract infection?...Yes...........No
*Inability to fall asleep due to pain?......................Yes...........No
No symptom relief with position change?.............Yes...........No
*Trauma/motor vehicle accident/fall?....................Yes...........No
Feeling down, depressed or hopeless?................Yes...........No
Little interest or pleasure in doing things?.............Yes...........No

Are you currently:

*Pregnant or trying to get pregnant?.....................Yes...........No
Depressed?..Yes...........No
Under stress?...Yes...........No

Check all that apply..... I currently have difficulty

___ Driving ___ Getting up from a chair
___ Walking ___ Bending at the Waist
___ Standing ___ Lifting

Surgical History: ______________________________________

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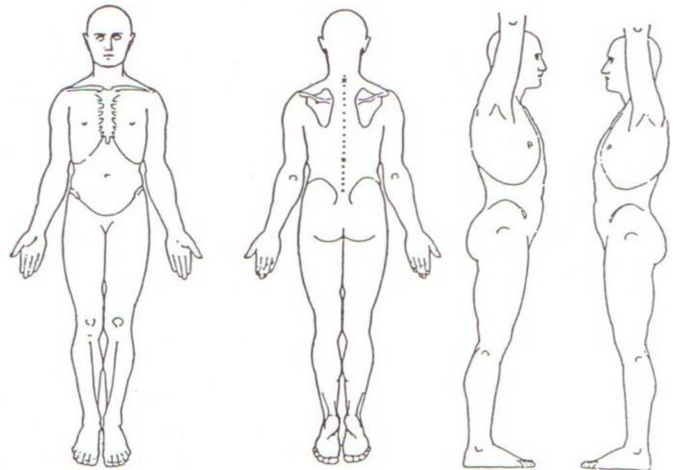
Name ____
Date of Birth ____
Contact Phone Number ___________________________________

Please circle YES or NO

Do you have a history of:

Allergies or Asthma?..Yes...........No
Headaches?..Yes...........No
*Migraine headaches?..Yes...........No
Bronchitis?...Yes...........No
Kidney disease?...Yes...........No
Rheumatic fever?..Yes...........No
Stomach ulcers?...Yes...........No
MRSA or C diff?..Yes...........No
Sexually transmitted disease?..............................Yes...........No
Seizures..Yes...........No
Hepatitis?...Yes...........No
*Tuberculosis?..Yes...........No
*Living with someone who had tuberculosis?.......Yes...........No
*Long term use of steroids?..................................Yes...........No
Trauma/motor vehicle accident/fall?.....................Yes...........No
*Anti-coagulation medications?..............................Yes..........No

Please mark the areas of your symptoms



Since the injury, have your symptoms: (check one please)
___ Gotten better ___ Stayed the same ___ Gotten worse

***Do you or have you smoked tobacco?** YES NO
If yes, _______ packs/day and for how long? ______________

Do you drink alcoholic beverages? YES NO
If yes, _________ drinks/week

Date of last physical examination ____________________

List medications currently using:

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