MEDICAL HISTORY SCREENING FORM

Please circle YES or NO where asked…..

Have you or any immediate family member ever been told that you or they have:

	SELF	FAMILY
Cancer?	YES / NO	YES / NO
* If YES, what type?	____________	____________
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
Osteoarthritis?	YES / NO	YES / NO
Rheumatoid Arthritis?	YES / NO	YES / NO

In the past 3 months have you had or experienced:

A change in your health? YES / NO
* If YES, what changed? ____________________________

Nausea/vomiting? YES / NO
Fever/chills/sweats? YES / NO
Unexplained weight change? YES / NO
Numbness or tingling? YES / NO
Changes in appetite? YES / NO
Difficulty swallowing? YES / NO
Changes in bowel or bladder function? YES / NO
Shortness of breath? YES / NO
Dizziness? YES / NO
Upper respiratory infection? YES / NO
Urinary tract infection? YES / NO

Are you currently:
Pregnant? YES / NO
Depressed? YES / NO
Under stress? YES / NO

Do you have a pacemaker? YES / NO

I currently have difficulty: (check all that apply)
_____ Driving _____ Getting up from a chair
_____ Walking _____ Bending at the waist
_____ Standing _____ Lifting

If you are accustomed to regular exercising, check the ones that give you difficulty now:
____ Playing sports ____ Running ____ Calisthenics

Please circle YES or NO where asked…..

Do you have a history of any of the following:

Allergies? YES / NO
* If YES, please list them:
____
____
____
____
____
____

* Latex allergy? YES / NO
* Bee sting allergy? YES / NO
Asthma? YES / NO
Headaches/Migraines? YES / NO
Bronchitis? YES / NO
Kidney disease? YES / NO
Rheumatic fever? YES / NO
Ulcers? YES / NO
Seizures? YES / NO

Are your symptoms: (please check one)
____ Getting worse ____ The same ____ Improving

Does your pain affect how you sleep? YES / NO
* If YES, is it: ____ Mild ____ Moderate
____ Severe ____ Can only sleep after taking medication

Do you have a problem with: (check all that apply)
___ Hearing ___Vision ___ Speech ___ Communication

How do you learn best?
___ Seeing ___ Doing Repeatedly ___ Hearing

Do you/have you smoked tobacco? YES / NO
* If YES, How much _________ / How often __________
How many years have you smoked? _________________
Last tobacco use: __________________________________

Do you drink alcoholic beverages? YES / NO
* If YES, How many drinks ______ / How often ________

Date of last physical examination: ___________________

Were you in a Motor Vehicle Accident? YES / NO
* If YES, date of accident:___________________________