MEDICAL HISTORY SCREENING FORM

Height ft in **Weight**

Check YES or NO

Have you or any immediate family member ever 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
Osteoarthritis	Yes	No	Yes	No
Rheumatoid arthritis	Yes	No	Yes	No

In the past 3 months have you had or did you experience:

A change in your health	Yes	No
Loss of strength or energy	Yes	No
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
Menstrual irregularities	Yes	No
Shortness of breath	Yes	No
Dizziness	Yes	No
Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No
Often been bothered by feeling down, depressed or hopeless	Yes	No
Been bothered by little interest or pleasure in doing things	Yes	No

Are you currently:

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 forward at the waist
Standing Lifting

If you are accustomed to regular exercising check the ones that give you difficulty now

Playing sports Running Calisthenics

Do you have a pacemaker or any medical implants? Yes No
If Yes, please list implants:

Do you have a history of: **Check YES or NO**

Allergies/Asthma	Yes	No
Headaches	Yes	No
Bronchitis	Yes	No
Kidney disease	Yes	No
Rheumatic fever	Yes	No
Ulcers	Yes	No
Sexually transmitted disease	Yes	No
Seizures	Yes	No
Testing positive for Tuberculosis	Yes	No
Living with someone who had Tuberculosis	Yes	No

Are your symptoms … (check one)

Getting worse The same Improving

How are you able to sleep at night? (check one)

Fine Moderate difficulty Only with medication
Awakened at night by pain Night Sweats

Do you have a problem with … (check all that apply)

Speech Communication Hearing Vision

How do you learn best?

Seeing Doing Hearing

Have you ever smoked tobacco? Yes No

If yes, Packs X Years.
Last tobacco use

Do you drink alcoholic beverages? Yes No

If yes, / week.

Date of last physical examination:

List medications currently using:

List any past surgeries / procedures with dates:

Signature______________________________

Date