MEDICAL HISTORY SCREENING FORM

Name: _____ Date: _____

Have you ever been told you have: **Circle YES or NO**

Allergies.....	YES	NO	Diabetes.....	YES	NO	*Osteoarthritis*.....	YES	NO
Anemia.....	YES	NO	Dizzy Spells.....	YES	NO	Osteoporosis.....	YES	NO
Anxiety.....	YES	NO	Emphysema/Bronchitis	YES	NO	Parkinson's.....	YES	NO
Arthritis.....	YES	NO	*Fibromyalgia*.....	YES	NO	Rheumatoid Arthritis...	YES	NO
Asthma.....	YES	NO	Fractures.....	YES	NO	Seizures.....	YES	NO
Cancer.....	YES	NO	Gallbladder Problems..	YES	NO	Speech Problems.....	YES	NO
Cardiac Conditions....	YES	NO	Hepatitis.....	YES	NO	Strokes.....	YES	NO
Cardiac Pacemaker.....	YES	NO	High Blood Pressure...	YES	NO	Thyroid Disease.....	YES	NO
Angina/Chest Pain.....	YES	NO	Incontinence.....	YES	NO	Tuberculosis.....	YES	NO
Chemical Dependency.	YES	NO	Kidney Problems.....	YES	NO	Ulcers.....	YES	NO
Circulation Problems...	YES	NO	Metal Implants.....	YES	NO	Vision Problems.....	YES	NO
Depression.....	YES	NO	Multiple Sclerosis.....	YES	NO			

In the <u>past 3 months</u> have you had or experienced any:

Changes in your health?.....	Yes	No
Headaches?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/Chills/Sweats?	Yes	No
Unexplained weight loss?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Shortness of breath?	Yes	No
Upper respiratory infection?.....	Yes	No
Pneumonia?	Yes	No
Urinary tract infection?	Yes	No
Changes in bowel or bladder function?	Yes	No
Lumps or thickening of the skin?	Yes	No

Are your symptoms: (check one)

□ Getting worse □ The same □ Improving

How are you sleeping at night? (check one)

□ Fine □ Moderate Difficulty □ Only with medication

Do you drink alcoholic beverages? Yes No

If yes, _____ drinks per week

Do/Did you used to smoke?.....**Yes No**

If yes to either of the above:

_____ packs per day

_____ years, last tobacco use _____

Are you pregnant? ..... **Yes No**

Height_____Weight_____

Date of last physical examination:

_____

Do you have any of the following:

Transplanted Organ.....**Yes No**

Joint Replacements .....**Yes No**

Please list current medications:

_____

_____

Please list any operations you have had and when:

_____

_____