Patient Name: ______________________

Date: __________________

MEDICAL SCREENING FORM

Select 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
Head/Neck Trauma?	Yes	No	Yes	No

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

- A change in your health? .... 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
- Changes in bowel or bladder function? .... Yes No
- Shortness of breath? .... Yes No
- Dizziness? .... Yes No
- Upper respiratory infection? .... Yes No
- Urinary infection? .... Yes No

In the past year have you had 2 weeks or more during which you felt sad, blue, depressed or when you lost all interest in things that you usually cared about for enjoyed? .... Yes No

Have you felt sad or depressed much of the time in the past year? .... Yes No

Have you had any trauma to your head and neck (i.e. blunt trauma, fall, ejection from auto, etc.)? .... Yes No

Select Yes or No...

Do you have a history of:

- 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

Are you currently:

- Pregnant? .... Yes No
- Under Stress? .... 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

Check all that apply ...

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

☐Hearing ☐Vision

☐Speech ☐Communication

Do you or have you in the past smoked tobacco?

YES NO

If Yes, _______ Packs _______ Year.

Last tobacco use ______________

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _______ /week.

Date of last physical examination ______________

List medication currently using:

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