DATE: ___________

MEDICAL SCREENING FORM

Circle 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 do you experience:

- A change in your health ?................. 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
- Shortness of breath ? .... Yes .... No
- Dizziness ?... Yes..... No
- Upper respiratory infection ?............ Yes..... No
- Urinary tract infection ? .... Yes..... No

Patient Information:

Circle 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
- Depressed ? .... 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 **X** __________Years.

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 medications currently using:

____

____

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY: Pins & Needles = 00000 **Stabbing = /////**
Burning = XXXXX **Deep Ache = zzzzz**