

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
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

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

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:
