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:

____

____

____