Medical History Screening Form

Have you ever been told that you have:

Condition		
Cancer	Yes	No
Diabetes	Yes	No
High Blood Pressure ..	Yes	No
Heart Disease	Yes	No
Angina/Chest Pain	Yes	No
Stroke	Yes	No
Osteoporosis	Yes	No
Osteoarthritis	Yes	No
High Cholesterol	Yes	No
Rheumatoid arthritis ...	Yes	No
HIV......................	Yes	No

Do you have a history of:

Condition		
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
Brain Injury / Concussion	Yes	No
Thyroid Disorder	Yes	No

Have you recently experienced:

Symptom		
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 or pain with bowel or bladder function	Yes	No
Pain with cough / sneeze	Yes	No

Are you currently:

Pregnant	Yes	No
Depressed	Yes	No
Under stress ...	Yes	No

Have you had any recent illnesses that have included:

Upper respiratory infections	Yes	No
Urinary tract infections	Yes	No

Have you had any of the following tests for *this injury / condition?*

X-rays Yes No ***MRI*** Yes No ***C-T Scan*** Yes No

Other (please list): ____

Do you have: *Pacemaker* Yes No *Defibrillator* Yes No *Cochlear Implant* Yes No

List any medications you are currently taking: ____

____

Have you had any previous injuries / surgeries? Please list. Yes No

____

Have you had previous treatment for this condition? Yes No

Physical Therapy _____ **Chiropractic** _____ **Injections** _____ **Other** ________________

Do you or have you in the past used tobacco? Yes No

Type used ____________ # of years _____________ amount ________ Last time used (date) _____________

Do you drink alcoholic beverages? Yes No Last time used (date) _____________

Occupation: ____

Activities and hours involved (sitting, standing, bending, walking, lifting, etc)

Sports, hobbies, other activities and frequency/hours involved:

____

Please list other medical conditions:

____

Name:____**Date:**_________________________________