Total Care
physical therapy, p.c.

MEDICAL SCREENING FORM

(Please complete entirely)

Name:_____ Date:_____/_____/_____

CIRCLE: (Y)YES or (N)NO

Have you or any immediate family member ever been told you have:

	Self		Family	
Cancer ?	Y	N	Y	N
Diabetes ?	Y	N	Y	N
High blood pressure ?	Y	N	Y	N
Heart disease ?	Y	N	Y	N
Angina/chest pain ?	Y	N	Y	N
Stroke ?	Y	N	Y	N
Osteoporosis ?	Y	N	Y	N
Osteoarthritis ?	Y	N	Y	N
Rheumatoid arthritis ?	Y	N	Y	N
Head/Neck Trauma ?	Y	N	Y	N

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

A change in your health ?	Y	N
Nausea/Vomiting ?	Y	N
Fever/chills/sweats ?	Y	N
Unexplained weight loss ?	Y	N
Numbness or tingling ?	Y	N
Changes in appetite ?	Y	N
Difficulty swallowing ?	Y	N
Changes in bowel or bladder function ?	Y	N
Shortness of breath ?	Y	N
Dizziness ?	Y	N
Upper respiratory infection?	Y	N
Urinary tract infection ?	Y	N

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 or enjoyed? Y N

Have you felt sad or depressed much of the time in the past year? Y N

Have you had any trauma to your head and neck (i.e blunt trauma, fall, ejection from auto etc) Y N

CIRCLE: (Y)YES or (N)NO

Do you have a history of:

Allergies/Asthma ?	Y	N
Headaches ?	Y	N
Bronchitis ?	Y	N
Kidney disease ?	Y	N
Rheumatic fever ?	Y	N
Ulcers ?	Y	N
Sexually transmitted disease ?	Y	N
Seizures ?	Y	N

Are you currently:

Pregnant ?	Y	N
Under Stress ?	Y	N

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only w/ 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? Y N

If yes,_____Packs X_____Years.
Last tobacco use_____

Do you drink alcoholic beverages? Y N

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

Date of last physical examination _____/_____/_____

List medications currently using:_____

_____

_____