S.P.O.R.T.
PHYSICAL THERAPY CLINIC

MEDICAL HISTORY SCREENING FORM

Name:_____ Date:_____

Select Yes or No…

Have you or any immediate family members 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 and/or vomiting?	☐YES	☐NO
Fever/chills/sweats?	☐YES	☐NO
Unexplained weight change?	☐YES	☐NO
Numbness or tingling?	☐YES	☐NO
Changes in bowl or bladder function?	☐YES	☐NO
Shortness of breath?	☐YES	☐NO
Dizziness?	☐YES	☐NO
Upper respiratory infection?	☐YES	☐NO
Urinary tract infection?	☐YES	☐NO

Patient Provide Medication List?

☐YES ☐NO

Medication List:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 diseases?	☐YES	☐NO
Seizures?	☐YES	☐NO

Other Medical Conditions:

_____

_____

_____

Previous Surgeries:

_____

_____

_____

_____

Are you currently:

Pregnant?	☐YES	☐NO
Depressed?	☐YES	☐NO
Under Stress?	☐YES	☐NO

Do you currently have a pacemaker installed? ☐YES ☐NO

How are you able to sleep at night:

☐No Problems ☐Moderate Difficulty ☐Only w/Medication

Do you or have you in the past smoked tobacco? ☐YES ☐NO

If yes, _____ packs x _____ years

Date of last physical examination: _____

Pain Rating:
This list provides some examples that might describe your pain. Check all that apply.

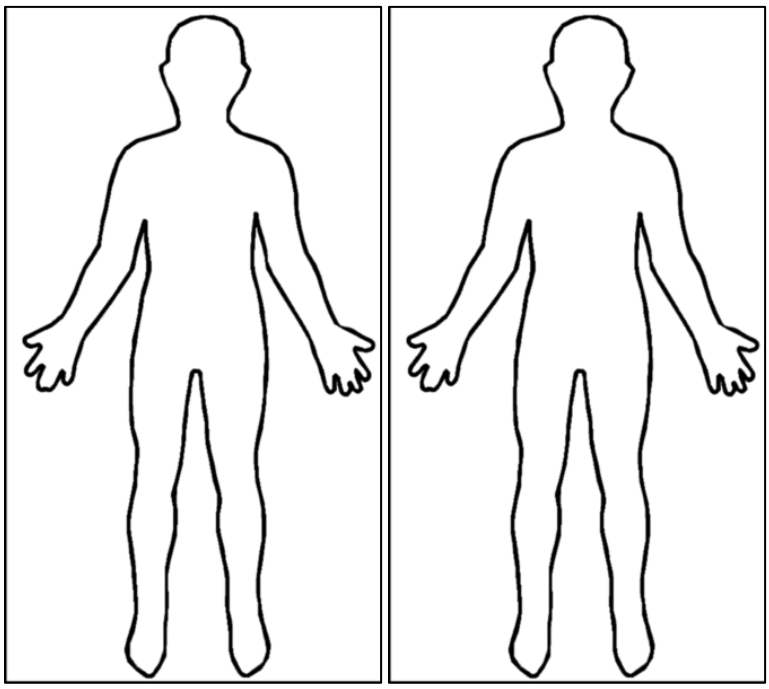
☐ Burning	☐ Dull	☐ Numb
☐ Sharp	☐ Shooting	☐ Stabbing
☐ Throbbing	☐ Tight	☐ Tingling

Are your pain symptoms:

☐ Constant (Never quits) ☐ Intermittent (Relieved w/some positions or rest)

☐ Occasional (Daily or less) ☐ Infrequent (Once a week or less)

On the chart below, mark each area of your pain or symptoms.



Front **Back** **Therapist Initial:** _____