DATE:_____ NAME:_____

DIAGNOSIS:_____

MEDICAL HISTORY SCREENING FORM

Middletown Holmdel Physical Therapy

Circle 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
Elevated Cholesterol	Yes	No	Yes	No

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

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 in Bowel/Bladder Function	Yes	No
Shortness of Breath	Yes	No
Dizziness	Yes	No
Upper Respiratory Infection	Yes	No
Urinary Tract Infection	Yes	No

Surgeries/Orthopedic History: Please list below

Circle YES or NO

Do you have a history of:

Allergies/Asthma	Yes	No
Heacaches	Yes	No
Bronchitis	Yes	No
Kidney Disease	Yes	No
Rheumatic Fever	Yes	No
Ulcers	Yes	No
Sexually Transmitted Disease	Yes	No
Infectious Disease	Yes	No
Seizures	Yes	No
Two or more falls in the past year	Yes	No
Any fall with injury in the past year	Yes	No

Are you currently:

Pregnant	Yes	No
Depressed	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 [ ]With Moderate Difficulty
[ ]Only with Medication

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