

MEDICAL SCREENING FORM

NAME: _____

DATE: _____

Circle YES or NO...

Have you ever been told you have...

Cancer.....YES NO

Diabetes.....YES NO

High Blood Pressure.YES NO

Heart Disease.....YES NO

Stroke..... YES NO

Osteoporosis.....YES NO

Osteoarthritis.....YES NO

Rheumatoid Arthritis.....YES NO

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

Change in health.YES NO

Nausea/Vomiting.YES NO

Fever/Chills/Sweats.....YES NO

Unexplained Weight Change...YES NO

Numbness or Tingling.....YES NO

Change in Appetite..YES NO

Difficulty Swallowing.....YES NO

Change in bowel or bladder

Function.....YES NO

Shortness of Breath.....YES NO

Dizziness.....YES NO

Pain at night.....YES NO

Do you have a history of ...

Allergies/Asthma.YES NO

Headaches.....YES NO

Major Surgery.....YES NO

Describe _____

Seizures..... YES NO

Are you currently...

Pregnant.....YES NO

Depressed/Stressed.YES NO

Are your symptoms: (check one)

Getting worse The same Improving

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

Please list your current medications:

Have you had any medical imaging performed for your current condition? (check all the apply)

[] X-rays [] MRI Other

Please label the diagram on the back of this page based on your current condition.

following k to d cate e diff nt typ o ymptom

KEY P ns & Need e 00000 Stabb n. //
Burn ng XXXXX Deep Ache zzzzz

