

Medical Screening Questionnaire

Answering the following questions will help us to manage your care better. Some of the questions may seem like they do not apply to your condition, but your activities of daily life affect your rehabilitation. Please complete all pages prior to your appointment. If you need additional room, please use the last page of this form or the back. Thank you.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Date of last doctor visit: _____

What is your primary concern for today's visit? _____

Special tests doctor has performed for your condition: _____

Do you now have or have you had a history of the following? Explain checked responses and include dates.

Medical History

- | | | |
|----------------------------------------|----------------------------|-------------------------------|
| Cancer—Type _____ | Diabetes | HIV/AIDS |
| Heart disease | Multiple Sclerosis | Epilepsy |
| High Blood Pressure | Rheumatoid arthritis | Allergies |
| Pacemaker/Defibulator | Osteoporosis | Allergic to Latex |
| Stroke | Osteopenia | Low back pain/sciatica |
| Circulation Problems (CVI/Blood Clots) | Other arthritic conditions | Joint Problems |
| Asthma | Depression | Broken Bones |
| Emphysema/Bronchitis | Hepatitis | Sexually transmitted diseases |
| Smoking habit | Tuberculosis | Pelvic pain |
| Chemical dependency (alcohol, drugs) | Kidney disease | Abdominal Pain |
| Thyroid problems | Anemia | Pelvic Trauma |

Have you recently noted:

- | | | |
|------------------|----------|----------------------|
| Weight Loss/gain | Fatigue | Fever/chills/sweats |
| Nausea/vomiting | Weakness | Numbness or tingling |

Explanations of above checked responses _____

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Medications

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

- | | | |
|------------------------|----------------|------------------------------|
| Aspirin | Laxatives | Antacid |
| Tylenol | Decongestants | Vitamins/Mineral supplements |
| Advil/Motrin/Ibuprofen | Antihistamines | Other _____ |

List any **PRESCRIPTION** medication you are currently taking (including pills, injections and/or skin patches):

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____ How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Surgical History

- | | | |
|----------------------------------|--------------------------------|----------------------|
| Surgery for your back/spine | Surgery for your female organs | Surgery for bladder |
| Surgery for your brain | Surgery for abdominal organs | Surgery for Prostate |
| Other type please describe _____ | | |

Explanations of above checked responses _____

