South Bay Sports and Physical Therapy
Medical History Screening Form

Name______________________________ **Date:**______________________

Circle YES or NO

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

	SELF		FAMILY	
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
High B.P.	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 <u>your</u> health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/Chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness/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

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

I currently have difficulty:(circle all that apply)

Walking — Bending at waist
Standing — Getting up from chair
Lifting — Driving

Do you exercise regularly? Yes No
What is the exercise?____________
Changes?
can't perform — perform less often

P.T. Use Only:
Height_________ Pulse___________
Weight_________ B.P.___________
Stated or Actual

Do you have a history of:

Asthma	Yes	No
Headaches	Yes	No
Bronchitis	Yes	No
Kidney Disease	Yes	No
Rheumatic Fever	Yes	No
Ulcers?	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?	Yes	No

Are your symptoms: (circle one)
Getting worse — the same — improving

How are you able to sleep at night?
fine — moderate difficulty — only with medication

Do you have a problem with:
(circle all that apply)
Hearing — Speech
Communication — Vision

How do you learn best?
Seeing — Doing — Hearing

Do you smoke, or have you in the past?
Yes No
If yes, ______ packs for ______ years.
Last tobacco use__________

Do you drink alcoholic beverages?
Yes No
If yes, ________ times a week

Date of last physical examination?___

List current medications:__________
____

List allergies:__________________
____

Surgical Procedures:______________
____

INSTRUCTIONS

Rate your major area of pain on the 0-10+ Pain Rating Scale. Write the number of your pain at the present time and your best day and your worst day over the past 30 days. Remember, the numbers refer to your pain, not how strong or weak you feel. For Example: No. 1 is Very Weak Pain and No. 7 is Very Strong Pain.

10+ -- Maximal

10 -- Very, Very Strong

9 --

8 --

7 -- Very Strong

6 --

5 -- Strong

4 -- Somewhat Strong

3 -- Moderate

2 -- Weak

1 -- Very Weak

0.5 -- Very, Very, Weak

0 -- Nothing At All

YOUR PAIN RATING

Pain Now ________

OVER PAST 30 DAYS {

Best Day ________

Worst Day ________