

Medical History Screening Form

Name: _____ Date: _____

Who is your primary care physician/pediatrician and phone #: _____

Are you on any medical restrictions? NO YES please explain: _____

Are you currently seeing any of the following for other than normal care?

MD/DO	YES	NO
Dentist	YES	NO
Counselor	YES	NO
Physical Therapist	YES	NO
Chiropractor	YES	NO

If yes please explain: _____

Have you or someone in your immediate family been diagnosed as having any of the following?

	YOU		IMMEDIATE FAMILY	
Cancer	YES	NO	YES	NO
Heart problems	YES	NO	YES	NO
High blood pressure	YES	NO	YES	NO
Asthma	YES	NO	YES	NO
Emphysema	YES	NO	YES	NO
Chemical dependency	YES	NO	YES	NO
Thyroid problems	YES	NO	YES	NO
Diabetes	YES	NO	YES	NO
Multiple sclerosis	YES	NO	YES	NO
Rheumatoid arthritis	YES	NO	YES	NO
Other arthritic conditions	YES	NO	YES	NO
Depression	YES	NO	YES	NO
Hepatitis	YES	NO	YES	NO
Tuberculosis	YES	NO	YES	NO
Stroke	YES	NO	YES	NO
Kidney disease	YES	NO	YES	NO
Anemia	YES	NO	YES	NO
Epilepsy	YES	NO	YES	NO
STD	YES	NO		
Other _____				

If yes please explain: _____

Please list any surgeries or other conditions you have been hospitalized for including dates:

MEDICATIONS	REASONS FOR TAKING	FOR HOW LONG	DOSAGE

In the past 3 months have you experienced?

Fever/Chills/Sweats	YES	NO	explain: _____
Unexplained weight change	YES	NO	explain: _____
Loss of energy/lethargic	YES	NO	explain: _____
Nausea/vomiting	YES	NO	explain: _____
Bowel changes	YES	NO	explain: _____
Numbness	YES	NO	explain: _____
Fainting	YES	NO	explain: _____
Dizziness/lightheadedness	YES	NO	explain: _____
Night pain	YES	NO	explain: _____
Difficulty breathing	YES	NO	explain: _____
Difficulty with urination	YES	NO	explain: _____
Sexual dysfunction	YES	NO	explain: _____
Currently pregnant	YES	NO	explain: _____
Increased stress	YES	NO	explain: _____
Depressed	YES	NO	explain: _____

Do you exercise or play sports? NO YES what and how many days per week: _____
Do you smoke? NO YES _____Packs/day _____Number of years
Do you drink alcohol? NO YES _____Drinks/day
How well do you sleep? Great Fine Not well
How much water do you drink _____glasses/day

Comments: _____

