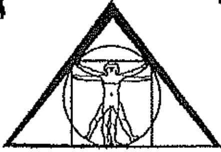


REHABILITATION SPECIALIST

MEDICAL HISTORY SCREENING FORM

Circle YES or NO

Have you or any immediate family member 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

In the past 3 months have you had or do you Experience:

A change in your health?	Yes	No
Loss of strength or energy	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 or Bladder function?	Yes	No
Menstrual irregularities	Yes	No
Shortness of breath?	Yes	No
Dizziness	Yes	No
Upper Respiratory infection?	Yes	No
Urinary Tract Infection	Yes	No
Often been bother by feeling down Depressed or hopeless	Yes	No
Been bothered by little interest or Pleasure in doing things?	Yes	No

Are you Currently:

Pregnant	Yes	No
Depressed	Yes	No
Under Stress	Yes	No

Check all that apply..I currently have difficulty

- ◯ Driving
- ◯ Getting up from a chair
- ◯ Walking
- ◯ Bending at the waist
- ◯ Standing
- ◯ Lifting

If you are accustomed to regular exercising check The ones that give you difficulty now

◯ Playing Sports ◯ Running ◯ Calisthenics

Circle YES or NO

Do you have a history of:

Allergies/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
Testing positive for Tuberculosis?	Yes	No
Living with someone who had tuberculosis?	Yes	No

Are your symptoms: (check one)

◯ Getting worse ◯ The Same ◯ Improving

How are you able to sleep at night? (check one)

◯ Fine ◯ Moderate Difficulty ◯ Only with meds

Check all that apply...

Do you have a problem with...

◯ Hearing ◯ Vision
◯ Speech ◯ Communication

How do you learn best?

◯ Seeing ◯ Doing ◯ Hearing

Do you or have you in the past smoked tobacco?

◯ Yes ◯ No

If yes, __________packs x______________Years

Last tobacco use ______________________

Do you drink alcoholic beverages? ◯ Yes ◯ No

If yes, _________________/week

Date of Last physical examination ______________

List medications currently using:

____

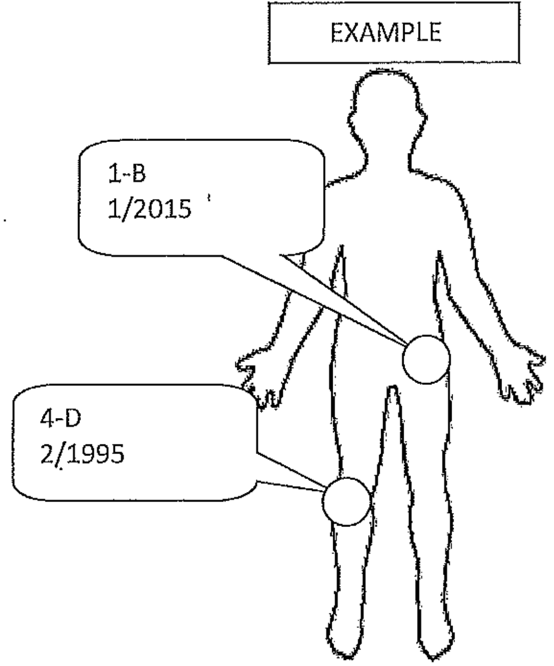
____

____

____

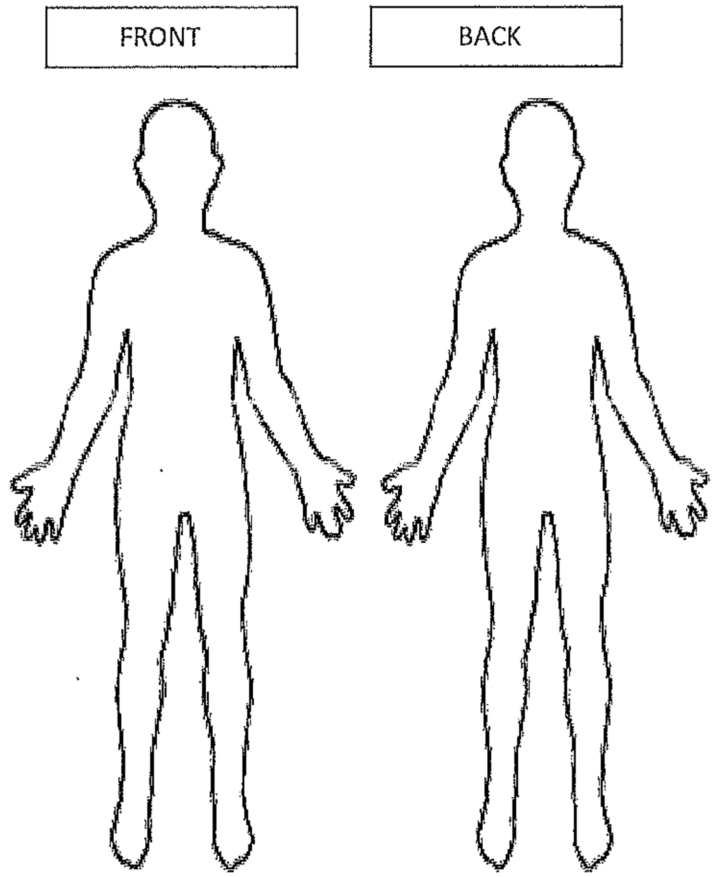
▷ This list provides some examples of words that may help describe your pain Use all that apply:

#1 Sharp	#7 Tingling
#2 Shooting	#8 Numb
#3 Burning	#9 Heavy
#4 Dull	#10 Tight
#5 Throbbing	#11 Pulling
#6 Ache	#12 Stabbing



▷ This list provides words that may help describe the behavior of your symptoms

A. Constant (never goes away)
B. intermittent (relieved with some positions or rest)
C. occasionally (daily or less frequent)
D. infrequently (once a week or month)
E. previously (no longer present)
F. variable (sometimes worse than other times)



INSTRUCTIONS:

1. Draw each area of your pain or other symptoms onto the chart.
2. Choose the corresponding number and letters from the previous lists to describe your symptoms or use your own words.
3. Put the date each area of symptoms started for this episode to the best of your memory.