MEDICAL SCREENING QUESTIONNAIRE

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
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/bladder function	Yes	No
Shortness of breath	Yes	No
Dizziness/fainting	Yes	No
Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No

Have you ever had surgery? Yes No

If yes, please describe: ______________________________

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List any other major injuries, fractures, etc.: ____________

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Circle YES or NO

Do you have a history of:

Allergies/asthma	Yes	No
Headaches	Yes	No
Kidney disease	Yes	No
Rheumatic fever	Yes	No
Ulcers	Yes	No
Sexually Transmitted Disease	Yes	No
Seizures	Yes	No
Head injury	Yes	No

(Women) Are you currently pregnant? Yes No

Are your symptoms: (circle one)

Getting worse The same Improving

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

Fine Moderate difficulty Only with Medication

Do you feel you have hearing loss? Yes No

During the past month have you been bothered by or felt down, depressed, or helpless? Yes No

During the past month have you often been bothered by or had little interest in or pleasure doing things?

Yes No

Is this something for which you'd like help? Yes No

Do you currently or have you in the past used tobacco?

Yes No If yes, ________ Packs X ________Years

Last tobacco use: ______________________________

List any medications currently using: __________________

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