MEDICAL HISTORY SCREENING FORM
Northwood Physical Therapy (Tayese LLC)

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
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
Often been bothered by feeling down depressed or hopeless	Yes......No
Been bothered by little interest or pleasure in doing things	Yes......No
Heartburn	Yes......No
Back Pain	Yes......No
Chronic cough	Yes......No
Yellow Jaundice	Yes......No
Hip Pain	Yes......No
Gout	Yes......No
Antibiotics Procedures	Yes......No
Knee Pain	Yes......No
Bleeding	Yes......No

Are you currently:

Pregnant	Yes......No
Depressed	Yes......No
Under stress	Yes......No

***Date of last PSA test? (MALES 50+-------------)**

Check all that apply....I currently have difficulty with:

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

☐ Bladder/bowel ?__________________

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
Hiatus Hernia	Yes......No
Latex allergy	Yes......No
Artificial Joints, Pins	Yes......No
Heart Arrhythmia	Yes......No
Hepatitis	Yes......No
Pace Maker	Yes......No
Emphysema	Yes......No
Thyroid trouble	Yes......No

Have you had any of the following?

MRI ☐ X-Ray ☐ CT Scan ☐ EMG ☐

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

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

☐ Fine ☐ Moderate difficulty ☐ Only on medication

Check all that apply:

Do you have a problem with: (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

How do you learn best?

☐ Seeing ☐ Doing ☐ Hearing

Do you smoke, chew tobacco or use a pipe? YES NO

If yes, how many packs/pipes/ pouches/ sticks a day_____

How many months or years__________________________

I used to smoke/chew but I quit: YES NO

If yes, pack or amount /day______________/ week

Do you drink alcoholic beverages? YES NO

Date of last physical examination: ____________________

List medications currently using: (may use reverse side or attach a list).

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