

## Musculoskeletal Medical Screening

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Circle YES or NO...**

**Have you or any immediate family member ever been told you have:**

	<u>Self</u>	<u>Family</u>
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 or  
bladder function?..... Yes.....No  
Shortness of breath?..... Yes.....No  
Dizziness?..... Yes.....No  
Upper respiratory infection?.... Yes.....No  
Urinary tract infection?..... Yes.....No  
Change in your balance(falls)?... Yes.....No

**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, how many drinks do you routinely have per week? \_\_\_\_\_/week.

**Date of Last Physical examination** \_\_\_\_\_

**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

**Are you currently:**

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

**Are your symptoms: (check 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.....**

(check all that apply)

Hearing                       Vision  
 Speech                       Communication

**My symptoms are worse in the:**

Morning                       Afternoon  
 Evening                       Night

**My symptoms are the best in the:**

Morning                       Afternoon  
 Evening                       Night

**List medications currently using:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other medical problems not covered above, surgeries, and major accidents/falls:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_