BEYOND REHAB
HEALTH AND FITNESS

Past Medical History Screening

To better understand your current medical condition; please complete the following. Thank you.

Please circle yes or no to the following:

Have you or any of your immediate family ever been diagnosed with the following.	Patient	Family
Diabetes?	Yes/No	Yes/No
High blood pressure?	Yes/No	Yes/No
Heart disease?	Yes/No	Yes/No
Heart attack?	Yes/No	Yes/No
Cancer?	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
Blood Clots?	Yes/No	Yes/No
Anemia?	Yes/No	Yes/No
Any other diagnosis? _____ _____		

Please answer the following:	
Do you drink alcohol?	Yes/No
Do you smoke?	Yes/No
Are you under stress?	Yes/No
Describe your activity level.	Minimal/Moderate/High
Date of last medical examination	____/_____/_____

Do you have a history of the following:		Do you have a history of the following:	
Bronchitis?	Yes/No	Pacemaker?	Yes/No
Kidney disease/ problems?	Yes/No	Nervous Disorder/ Anxiety?	Yes/No
Allergies/Asthma?	Yes/No	Dizziness/Balance disorders?	Yes/No
Rheumatic fever?	Yes/No	Lightheadedness?	Yes/No
Ulcers?	Yes/No	Are you pregnant?	Yes/No
Sexually transmitted disease?	Yes/No	Depression?	Yes/No
Seizures?	Yes/No		
Hernia?	Yes/No		
Metal implants?	Yes/No		

Please list any of your current Medications below:

Please list your past surgical history below:	
1	Approximate Date: _____/_____/_____
2	Approximate Date: _____/_____/_____
3	Approximate Date: _____/_____/_____
4	Approximate Date: _____/_____/_____
5	Approximate Date: _____/_____/_____
6	Approximate Date: _____/_____/_____

Have you RECENTLY experienced any of the following (circle all that apply)?

Fatigue	*Muscle weakness*	*Shortness of breath*
Fever/chills/sweats	*dizziness/lightheadedness*	*Fainting*
Nausea/vomiting	*Heartburn/indigestion*	*Cough*
Weight loss/gain	*Difficulty swallowing*	*Headaches*
Falls	*Changes in bladder or bowel function*	*Balance deficits*
Constipation	*Numbness or tingling*	*Diarrhea*