DATE: _____

oregon running clinic

MEDICAL 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 ☐
- 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 ☐

Patient Information:

NAME _____

PHONE: _____

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? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

Check all that apply…

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

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

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 _____

List medications currently using:

_____

_____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY: Pins & Needles = 00000 Stabbing = /////
Burning = XXXXX Deep Ache = zzzzz