

## MEDICAL HISTORY

Do you have a history of:

	YES	NO	EXPLANATION
Diabetes			
Cancer			
Shortness of breath			
Painful urination			
Fever/Chills/Sweats			
Heart disease			
High blood pressure			
Aneurysms (including family)			
Substance abuse			
Lung disease			
Malaise (fatigue)			
Nausea/ Vomiting			
Fainting spells			
Surgery			
Recent weight loss or gain			
Fracture			
Recent hospitalization			
Any other medical conditions			

Do you have a problem with:

Bowel or bladder control			
Dizziness/Lightheadedness			
Earache			
ringing in ears			
Chewing			
Grinding teeth			
Night pain			
Numbness			
Weakness			

Are you pregnant ?	
Do you take birth control pills or hormones ?	
Do you have a pacemaker or metal implants	
Have you had any recent illnesses in the past 3 wks ? (colds, influenza, kidney or bladder infection)	
Have you noticed any lumps or thickening of skin or muscle anywhere on your body ?	
Do you have any sores that have not healed or any change in size, shape or color of a wart or mole ?	
Do you smoke or chew tobacco? If so, how much ?	
How much caffeine do you consume daily ? (including soft drinks, tea or chocolate)	

Has this problem caused you to miss time from work?	
Are you better, worse or same since problem began ?	
Have you ever worn a brace or splint or shoe lift ?	
Have you had similar problems before ?	
Have you had physical therapy before ?	
Did it help?	
What was done?	