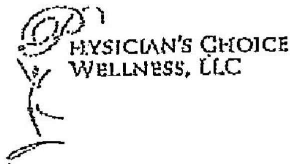


Date: ____________

Name: ____________

DOB: ____________

# Initial Screening Physical Questionnaire

Primary Care Physician: ____________________________________________

Name Address Phone

## MEDICATIONS

Please list ALL medications, including prescription drugs and OTC medications. (You may attach a list)

| Drug | Dosage | Frequency |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

List All Allergies ____________________________________________

*DO YOU HAVE* (please circle)

| | | |
|---|---|---|
| Hypertension/High BP | Yes | No |
| Heart Disease | Yes | No |
| Gout or hyperuricemia | Yes | No |
| Degenerative arthritis | Yes | No |
| Any kind of arthritis | Yes | No |
| If yes, what kind? ____________ | | |
| Diabetes Mellitus | Yes | No |
| High Cholesterol of triglyceride | Yes | No |
| Liver Disease | Yes | No |
| If yes, do you have a special diet? ____________ | | |
| Kidney Disease | Yes | No |
| If yes, do you have a special diet? ____________ | | |
| Cancer | Yes | No |
| If yes, when was last treatment? ____________ | | |
| Stomach ulcers | Yes | No |
| Inflammatory bowel disease | Yes | No |

*HAVE YOU HAD* (circle)

| | | |
|---|---|---|
| Heart attack | Yes | No |
| If yes, when? ____________ | | |
| Cancer | Yes | No |
| If yes, what kind and when? ____________ | | |
| Cortisone/prednisone | Yes | No |
| If yes, when? ____________ | | |
| Bone fracture in past 3 months | Yes | No |
| If yes, what bone? ____________ | | |

PLEASE LIST ALL SURGERIES:

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Signature: ____________________________ Date: ____________