PTHEART Medical Screening Form

Name: _____ **Birthdate:** _____/_____/_____ **Gender:** □Male □Female
Mo Day Year

Why are you here? (Check one):
Health and Wellness…□ Physical Therapy……..□

Are you currently under the care of a primary medical doctor? (Check one)… □Yes…. □No

Do you currently have health insurance? (Check one)... □Yes…. □No

In the past 3 months have you had or do you experience? **(Check all that apply)…**

A change in your health?.....	□Yes…. □No	Change in appetite?.....	□Yes…. □No
Change in your balance (↑ Falls)?.....	□Yes…. □No	Change in bowel or bladder function?	□Yes…. □No
Depression?.....	□Yes…. □No	Difficulty Swallowing?.....	□Yes…. □No
Dizziness?.....	□Yes…. □No	Fever/Chills/Sweats?.....	□Yes…. □No
Numbness or Tingling?.....	□Yes…. □No	Shortness of Breath?.....	□Yes…. □No
Unexplained Weight Change?.....	□Yes…. □No	Under Stress?.....	□Yes…. □No

Difficulty Sleeping?…… □Yes…. □No…..**If Yes, are you able to sleep at night**? **(Check one)**
□Moderately Well □A lot of difficulty □Only with medication

Have you or any family members ever had the following? (Check all that apply)…

	Self	Family*
Cancer?……	□Yes….□No	□Yes….□No
Chest Pain?.....	□Yes….□No	□Yes….□No
Diabetes?.....	□Yes….□No	□Yes….□No
Heart Disease?.....	□Yes….□No	□Yes….□No
High Blood Pressure?...	□Yes….□No	□Yes….□No
Osteoarthritis?.....	□Yes….□No	□Yes….□No
Rheumatoid Arthritis?....	□Yes….□No	□Yes….□No
Stroke?.....	□Yes….□No	□Yes….□No

***grandparents, parents, aunts/uncles, and siblings**

Do you have or have you had an issue with?… (Check all that apply)

Allergies?…… □Yes….□No
Hearing?..... □Yes….□No
Headaches?…… □Yes….□No
Kidney Disease? …… □Yes….□No
Liver Disease? …… □Yes….□No
Lung Disease such as asthma/bronchitis?. □Yes….□No
Respiratory Infection such as pneumonia? □Yes….□No
Osteoporosis (bone weakness)?..... □Yes….□No
Sexually Transmitted Disease?…….... □Yes….□No
Seizures?..... □Yes….□No
Speech or communication?..... □Yes….□No
Ulcers (Stomach or Foot)?..... □Yes….□No
Vision?..... □Yes….□No
If female, is it possible you are pregnant? □Yes….□No

Do you currently take any medications for? (Check all that apply)

Anxiety □ Depression □ Blood Pressure□
Heart □ Diabetes □ Pain □
Other….□,specify:_____
_____

How many prescription medications are you currently taking?_____

Do you or have you in the past smoked tobacco?
□Yes…. □No

If yes:_____ Packs/Day **X** _____ Years

If Quit, the months or years since last Tobacco use
_____years_____months

Do you drink alcoholic beverages?
□Yes…. □No
If yes, how many drinks do you routinely have per week?
_____/week.

How much weekly activity do you usually engage in?

0min□	31-45min□	76-120min □
1-15min□	46-60min□	121-150min □
16-30min□	61-75min□	151-300min□

What is your preferred learning style (how do you learn best)?

Auditory(Hearing)□ Visual (Pictures) □
Hands-On(Feeling)□ Reading(Written Words)□

Patient Signature:_____ **Date:** _____

For SPT USE ONLY…

BP (1st & 2nd)	_____/_____	_____/_____	Ht _____ft____in	_____cm
HR (1st & 2nd)	_____bpm	_____bpm	Wt _____lbs	_____Kg
RR (1st & 2nd)	_____breaths/min	_____breaths/min		
BMI	_____Kg/m^2			