PhysioRehab Group
We Make You Stronger

HEALTH SCREEN

Name:_____ Date:_____

Date of birth:_____ Injury date:_____

Confidential health information, please answer them to best of your knowledge

1. Cardio Vascular:
   - Heart pain / chest pain □
   - Doctor said no for exercises □
   - High blood pressure □
   - Stroke / CVA □
   - Pacemaker □
   - Congestive Heart failure / Heart attack □
   - Swelling in leg or feet □
2. Infections:
   - Tuberculosis □
   - Skin condition □
   - Hepatitis □
   - Herpes □
   - Recent viral infection □
3. Respiratory:
   - COPD, Emphysema or asthma □
   - Difficulty breathing □
   - Persistent cough □
   - Bronchitis □
4. Other:
   - Dizziness / faint spells □
   - Ever had a seizure □
   - Any surgery in past year □
   - Any medications (Provide a list of prescribed medication) □
   - Female, if pregnant □
   - Female, other gynecological problem □
   - Diagnosed Depression / Anxiety □

- Weight loss or gain in past 2 months □
- Diabetes □
- Metal, pins, plates, screws inside a bone □
- Osteoporosis □
- Blood clots □
- Bowel / bladder problems □
- Cancer (Past or Present) □

5. List of prescribed medication and prescribing Physician's name:

_____

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6. Any other medical condition that we should be aware about and is not mentioned above:

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