PANTHER SPORTS MEDICINE & Rehabilitation Centres

Medical History

Please indicate if you currently have, or have had any of the following in the past.

GENERAL HEALTH	Current	Past
· Metal implants	☐	☐
· Total joint replacement	☐	☐
· Fractures/bone breaks	☐	☐
· Slurred speech	☐	☐
· Difficulty swallowing	☐	☐
· Sensation changes	☐	☐
· Cancer	☐	☐
· Unexplained weightloss	☐	☐
· Significant night pain	☐	☐
· Fever/Chills	☐	☐
· Night sweats	☐	☐
· Other Click here to enter text.	☐	☐

NERVOUS SYSTEM	Current	Past
· Epilepsy / seizures	☐	☐
· Stroke	☐	☐
· Other Click here to enter text.	☐	☐

INFECTIONS	Current	Past
· MRSA, VRE, C-Diff	☐	☐

EAR, NOSE, THROAT	Current	Past
· Hearing loss	☐	☐
· Ringing in ears	☐	☐
· Smell/taste issues	☐	☐
· Hoarseness	☐	☐
· Speech difficulty	☐	☐
· Other Click here to enter text.	☐	☐

DIGESTIVE SYSTEM	Current	Past
· Colitis/ISB	☐	☐
· Nausea	☐	☐
· Vomiting	☐	☐
· GERD / Heartburn	☐	☐
· Blood in Stool	☐	☐
· Ulcers	☐	☐
· Other Click here to enter text.	☐	☐

GENITOURINARY SYSTEM	Current	Past
· Bladder infection	☐	☐
· Bladder function change	☐	☐
· Blood in urine	☐	☐
· Change in sexual function	☐	☐
· Other Click here to enter text.	☐	☐

ENDOCRINE SYSTEM	Current	Past
· Diabetes	☐	☐
· Thyroid problems	☐	☐
· Other Click here to enter text.	☐	☐

RESPIRATORY SYSTEM	Current	Past
· Pain with cough / sneeze	☐	☐
· Chronic cough	☐	☐
· Coughing up blood	☐	☐
· Shortness of breath	☐	☐
· Asthma	☐	☐
· Other Click here to enter text.	☐	☐

CARDIOVASCULAR SYSTEM	Current	Past
· Bleeding Disorder	☐	☐
· Pacemaker	☐	☐
· High / low blood pressure	☐	☐
· High blood cholesterol	☐	☐
· Heart attack	☐	☐
· Chest pain / discomfort	☐	☐
· Irregular heart beat	☐	☐
· Leg / ankle swelling	☐	☐
· Other Click here to enter text.	☐	☐

SKIN	Current	Past
· Wounds / lesions / rashes	☐	☐
· Psoriasis	☐	☐
· Sensitive Skin	☐	☐

WOMENS HEALTH	Yes	No
· Are you pregnant?	☐	☐
· How many months Choose an item.		
· Other Click here to enter text.		

OTHER	Current	Past
· Rheumatoid Arthritis	☐	☐
· Other arthritic conditions	☐	☐
· Depression	☐	☐
· HIV or Hepatitis Click here to enter text.	☐	☐

I have none of the above and am in good health. ☐

ALLERGIES Do you have a latex allergy ☐ Yes ☐ No Do you have a tape allergy ☐ Yes ☐ No

Other allergies Click here to enter text.

FAMILY MEDICAL HISTORY - Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (Check the boxes that apply)

☐ Cancer	☐ Diabetes	☐ Tuberculosis
☐ Heart problems	☐ Stroke	☐ Thyroid problems
☐ High blood pressure	☐ Depression	☐ Blood clots