

**MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA**

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

**MUSCULOSKELETAL PAST & PRESENT MEDICAL SCREENING FORM**

OTSG APPROVED (Date)

MARK EACH ITEM IN QUESTIONS 1 - 4 "YES" or "No".

	FAMILY		SELF	
	YES	NO	YES	NO
1. Have you or any immediate family member ever been told you have:				
a. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Angina or chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		YES	NO
		2. In the past 3 months, have you had or are you currently experiencing:	
a. A change in your health		<input type="checkbox"/>	<input type="checkbox"/>
b. Nausea or vomiting		<input type="checkbox"/>	<input type="checkbox"/>
c. Fever, chills or sweats		<input type="checkbox"/>	<input type="checkbox"/>
d. Unexplained weight change		<input type="checkbox"/>	<input type="checkbox"/>
e. Numbness or tingling		<input type="checkbox"/>	<input type="checkbox"/>
f. Changes in appetite		<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty swallowing		<input type="checkbox"/>	<input type="checkbox"/>
h. Changes on bowel or bladder function		<input type="checkbox"/>	<input type="checkbox"/>
i. Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>
j. Dizziness		<input type="checkbox"/>	<input type="checkbox"/>
k. Upper respiratory infection		<input type="checkbox"/>	<input type="checkbox"/>
l. Urinary tract infection		<input type="checkbox"/>	<input type="checkbox"/>
m. Change in your balance (increased falls)		<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
	3. Do you have a history of:	
a. Allergies or asthma	<input type="checkbox"/>	<input type="checkbox"/>
b. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
c. Bronchitis or COPD	<input type="checkbox"/>	<input type="checkbox"/>
d. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
e. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
f. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
g. Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
h. Seizures	<input type="checkbox"/>	<input type="checkbox"/>

4. Are you currently:	YES	NO
a. Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
b. Depressed	<input type="checkbox"/>	<input type="checkbox"/>
c. Under stress	<input type="checkbox"/>	<input type="checkbox"/>

5. Are your symptoms: (check one)

Getting worse    The same    Improving

6. How are you able to sleep at night? (check one)

Fine    Moderate difficulty    Only with medication

7. Do you have a problem with: (check all that apply)

Hearing    Speech    Vision    Communication

8. I feel worse in the: (check one)

Morning    Afternoon    Evening    Night

9. I feel best in the: (check one)

Morning    Afternoon    Evening    Night

10. Smoking	YES	NO
a. Do you or have you in the past smoked tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
b. If "YES", _____ packs X _____ years.		
c. If "YES", Last tobacco use:		

11. Alcohol	YES	NO
a. Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
b. If "YES", how many drinks do you usually have per week?		

12. Date of your last physical exam:

13. List all prescription medications, over-the-counter medications and herbals that you are current taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's signature

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

HISTORY/PHYSICAL    FLOW CHART

OTHER EXAMINATION OR EVALUATION    OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT