

PELVIC/HIP PAIN MEDICAL SCREENING QUESTIONNAIRE

NAME: _____

DATE: _____

Medical Record #: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you recently had a trauma, such as a fall? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had a medical practitioner tell you that you have osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a medical practitioner tell you that you have a problem with the blood circulation in your hips? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking steroids or have you been on prolonged steroid therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your pain ease when you rest in a comfortable position? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a history of cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has a member of your immediate family (i.e., parents or siblings) been diagnosed with cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you recently lost weight even though you have <i>not</i> been attempting to eat less or exercise more? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had a recent change in your bowel functioning such as black stools or blood in your rectum? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had diarrhea or constipation that has lasted for more than a few days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have groin or thigh pain that increases when you cough or sneeze? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you feel sick to your stomach to the point where you feel like vomiting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. If female, have you recently experienced increased pain during your menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |