LANCASTER PHYSICAL THERAPY & SPORTS MEDICINE

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Age:**_____ **Date of Evaluation:**_____

Weight:_____ **Height**:_____ **Marital Status:**_____ **Gender:**_____

Main Problem (How/When & Pain/Symptoms):_____

_____

Other Treatment (PT, Chiropractic, etc.):_____

Date of Last Physical:_____ **Allergies:**_____

Tests (X-rays, MRI, Bone Scan):_____

Surgeries (include dates):_____

Medications: _____

MEDICAL SCREENING

*(Circle **YES** or **NO**)*

Have you or any immediate family member been told you have:

	Self		Family			Self		Family	
Cancer	Yes	No	Yes	No	Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Heart Disease	Yes	No	Yes	No
Angina/Chest Pain	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Thyroid condition	Yes	No	Yes	No
Do you have a history of:									
Allergies/Asthma	Yes	No			Rheumatic Fever	Yes	No		
Kidney Disease	Yes	No			Hepatitis	Yes	No		
Seizures	Yes	No			Bronchitis	Yes	No		
Headaches	Yes	No			Ulcers	Yes	No		
In the past 3 months have you had or do you experience:									
A change in your health	Yes	No			Nausea/vomiting	Yes	No		
Fever/chills/sweats	Yes	No			Unexplained weight change	Yes	No		
Numbness/tingling	Yes	No			Changes in appetite	Yes	No		
Difficulty swallowing	Yes	No			Changes in bowel	Yes	No		
Shortness of breath	Yes	No			Changes in bladder function	Yes	No		
Dizziness	Yes	No			Upper respiratory infection	Yes	No		
Urinary tract infection	Yes	No							
Are you currently:									
Pregnant	Yes	No							
Depressed	Yes	No							
Under Stress	Yes	No							
Have a pacemaker	Yes	No							

How are you sleeping at night? (check one) ( )fine ( ) moderate difficulty ( ) only with medication

Do you or have you smoked tobacco? (circle one) Yes No -- If yes: packs/day:_____ # of years:_____ last use:_____

I currently have difficulty with (check all that apply)

( )driving ( )getting up from a chair ( )walking ( )bending at the waist

Are your symptoms: (check one)

( )getting worse ( )same ( ) getting better

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:

SIGNATURE:_____ DATE:_____