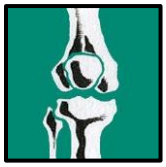
Patient Medical History Questionnaire

Hudsonville Physical Therapy



Name_____ Date_____

General

Medical History (Please check all that apply):

☐Diabetes	☐Vascular Problems	☐High Blood Pressure	☐Heart Disease ☐Cancer
☐Raynauds	☐Broken Bones	☐Pacemaker	☐Pregnant
☐Thyroid Problems	☐Pulmonary Problems	☐Seizures	☐Kidney Problems
☐Hiatal Hernia	☐HIV/AIDS	☐Smoking Habit	☐Alcoholism

Have you had: ☐Chemotherapy ☐Radiation Therapy ☐ Recent Infection
☐Infection ☐Recent Illness_____

Surgical

Surgical Procedures:

_____

Do you have any metal implants (screws, pins, plates, metal hip or knees) from previous surgeries? Yes___No____

Medications

Presently taking Medications? Yes___No____

If yes, list medications or give front desk a list: _____

_____

Allergies

Any allergies?

Yes___No____ If yes, list allergies: _____

Pain

Pain Scale: Do you have any pain related to your chief complaint?

Yes____No____

Duration of Pain: ☐ Constant ☐ Intermittent

Severity of Pain (circle): (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Daily Activity

Do you exercise regularly? Yes___ No___

Other

Are there any other medical problems that we should be aware of relative to your current problem? _____