



PATIENT & MEDICAL HISTORY QUESTIONNAIRE

Name _____ Referring Physician _____ Date _____

Diagnosis _____

Date of Onset _____ Weight _____ Height _____ Age _____

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

	<u>Self</u>	<u>Family</u>
Cancer	Yes...No	Yes...No
High Blood Pressure	Yes...No	Yes...No
Diabetes	Yes...No	Yes...No
Heart Disease	Yes...No	Yes...No
Angina/Chest pain	Yes...No	Yes...No
Stroke	Yes...No	Yes...No
Arthritis	Yes...No	Yes...No
Anemia	Yes...No	Yes...No

Do you have a history of:

Shortness of Breath	Yes...No
Allergies	Yes...No
Asthma	Yes...No
Bronchitis	Yes...No
Polio	Yes...No
Emphysema	Yes...No
Metal Implants	Yes...No
Are you Pregnant	Yes...No

Have you had or do you experience:

Surgery	Yes...No
Nausea/vomiting	Yes...No
Fever/chills/sweats	Yes...No
Unexplained weight change	Yes...No
Numbness or tingling	Yes...No
Muscular weakness	Yes...No
Fainting spells	Yes...No
Dizziness	Yes...No
Night Pain	Yes...No
Bowel or bladder changes	Yes...No
Headaches	Yes...No

If answered yes, please briefly explain and give approximate dates:

Describe the history of injury:

List current medications:

List the results of any diagnostic tests (i.e., X-rays, MRI, Bone scan, EMG, etc.):

PMH Questionnaire has been read and reviewed PT. Initials/License #: _____