Source Physical Therapy & Wellness

Patient Health History Questionnaire

Clincial Use ONLY: Patient Name: ______________________________

Patient ID #: ____________________ Date: ____________

Please answer the following health related questions to help us provide the most comprehensive physical therapy care possible. If you have any questions, please ask your physical therapist.

Have you ever been diagnosed with any of the following conditions ? ***DARKEN THE CIRCLE***

	NO	YES (within the last 12 months)	YES (diagnosed > 1 year ago)
1. Lung Cancer	O	O	O
2. Breast Cancer	O	O	O
3. Prostate Cancer	O	O	O
4. Colon Cancer	O	O	O
5. Skin Cancer	O	O	O
6. Bone Cancer	O	O	O
7. Leukemia Cancer	O	O	O
8. Lymphoma Cancer	O	O	O
9. Other Cancer: (list)			
____________________		O	O
____________________		O	O

	NO	YES
10. Chronic Urinary or Bladder Infections (3 or more within last year)	O	O
11. Pneumonia	O	O
12. Bone or Joint Infections	O	O
13. Pelvic Inflammatory Disease	O	O
14. Kidney Infection	O	O
15. Other Infection (list)		
____________________	O	O
____________________	O	O
16. Heart Attack	O	O
17. Heart Valve Problems	O	O
18. Blood Clots in Legs (DVT's)	O	O
19. Artery Blockage in Legs	O	O
20. High Blood Pressure	O	O
21. Stroke: Mini-Stroke	O	O
Transient Ischemic Attack	O	O
22. Anemia / Low Blood Levels	O	O

	NO	YES
23. Asthma	O	O
24. Emphysema	O	O
25. Alcoholism	O	O
26. Depression	O	O
27. Tuberculosis	O	O
28. Hypothyroid (low)	O	O
29. Hyperthyroid (high)	O	O
30. Diabetes (diagnosed before age 18)	O	O
31. Diabetes (diagnosed after age 18)	O	O
32. Multiple Sclerosis	O	O
33. Rheumatoid Arthritis	O	O
34. Degenerative (wear & tear) Osteoarthritis	O	O
35. Gout	O	O
36. Anklyosing Spondylitis	O	O
37. Hepatitis	O	O
38. Stomach Ulcers	O	O
39. Epilepsy / Seizures	O	O
40. Headaches (> 1/week)	O	O
41. Endometriosis	O	O
42. Urinary Incontinence	O	O
43. Osteoporosis	O	O

44. Any other illnesses diagnosed by a physician. Please List :

____

____

____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the conditions listed above ? If so, please list the diagnosis and the time frame of the diagnosis.

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Please describe any significant injuries (fractures, dislocations, sprains/strains, etc.) or surgeries (heart, appendix, gallbladder, bone or joint surgery, etc.) for which you have been treated for and provide the approximate date of the injury or surgery:

____

____

____

____

Which of the following medication have you taken in the last 2 weeks ?

Was this medication prescribed by a Medical Doctor ?

	NO	YES
Aspirin	O	O
Tylenol	O	O
Antiinflammatory (Advil, Motrin, Ibuprofen)	O	O
Cholesterol Medication	O	O
Stomach Ulcer Medication	O	O
Vitamins / Mineral Supplements	O	O
Herbal Remedies	O	O
Other medication (list) :		
____________________	O	O
____________________	O	O
____________________	O	O
____________________	O	O

How much caffeinated coffee or caffeine containing beverages do you drink per day ?
Please choose one:

do not drink any caffeine	O
1 - 2 cups per day	O
2 + cups per day	O

How many days per week do you drink alcohol ?
Please choose one:

do not drink alcohol	O
1 - 2 days per week	O
3 - 4 days per week	O
4 - 7 days per week	O

IF YOU DO DRINK ALCOHOL, how much do you drink on average ?
Please choose one:

1 - 3 drinks	O
4 drinks	O
5 + drinks	O

How many packs of cigarettes do you smoke per day ?

O Do Not Smoke O ____________ packs / day

IF YOU DO SMOKE, how long have you been smoking ? ____________ years

Physical Therapist Signature ____________ Date ____________ Patient Signature ____________ Date ____________

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