WAYNESBORO
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
Lupus	Yes	No	Fibromyalgia	Yes No
COPD/Emphysema	Yes	No	Lyme disease	Yes No
Multiple Sclerosis	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:_____