Owoc Physical Therapy & Associates, LLC

Medical History Questionnaire

Name: _____ D.O.B.: _____

Dx/ICD9 code: _____ M.D.: _____

	Yes	No	Comments
Are you now under the care of a Physician?	☐	☐	
Have you ever been Hospitalized? If so please explain.	☐	☐	
Have you ever broken or fractured a bone? If so please explain?	☐	☐	
Have you ever had any surgical procedure? If so please explain?	☐	☐	
Are you taking any medicines? Include prescription and non-prescription medication.	☐	☐	
Has there been any recent change in your appetite? If so please explain.	☐	☐	
Have you had any recent change in your weight (gain or loss of more than 5 pounds)? If so please explain	☐	☐	
Have you ever been diagnosed as having Thyroid trouble?	☐	☐	
Are you experiencing any recent weakness or fatigue?	☐	☐	
Are you experiencing any fever, chills or night sweats?	☐	☐	
Do you become dizzy or light headed? If so please explain.	☐	☐	
Are you experiencing any swelling?	☐	☐	
Do you have any intolerance to heat or cold?	☐	☐	
Have you had any recent irradiation exposure?	☐	☐	
Have you been diagnosed as having Diabetes?	☐	☐	
Have you ever been diagnosed or treated for Cancer or leukemia?	☐	☐	

Name: _____ DOB: _____

	Yes	No	Comments
Do you bruise or bleed easily?	☐	☐	
Do you have allergies or have you ever had an allergic reaction? If so, please explain	☐	☐	
Do you have or have you ever had difficulty seeing, double vision, cataracts, glaucoma, and eye infections eye pain? If so, please explain.	☐	☐	
Do you have or have you ever had a hearing loss, ringing in your ears, balance problems? If so please explain.	☐	☐	
Do you have dentures, or any surgeries for your teeth or gums?	☐	☐	
Do you have or have you ever had sores in area of tongue, gums, mouth?	☐	☐	
Do you have or have you ever had breast tenderness or discharge?	☐	☐	
Have you ever had Rheumatic Heart disease, Rheumatic Fever, Scarlet Fever, Heart Defect, Heart murmur, Heart Trouble, Heart Attack, Angina or chest pain? If so please explain.	☐	☐	
Do you have or have you ever had difficulty breathing, shortness of breath, asthma, lung or breathing problems, tuberculosis, persistent cough, cough that produces blood? If so please explain/	☐	☐	
Have you ever had heart surgery or a pacemaker implant? If so, please explain.	☐	☐	
Do you have high or low blood pressure?	☐	☐	
Do you have or have you ever had cramping in legs or arms, varicose veins, blood clots? If so please explain.	☐	☐	
Do you have or have you had recent nausea or vomiting?	☐	☐	
Do you have difficulty speaking or swallowing?	☐	☐	
Is there a change in your bowel habits?	☐	☐	
Do you have Increased gas or bloating?	☐	☐	
Do you have or have you ever had Hemorrhoids?	☐	☐	
Do you have or have you ever had a Hernia? If so please explain.	☐	☐	
Do you have or have you ever had a stomach ulcer?	☐	☐	
Do you have or have you ever had Hepatitis, Jaundice or Liver disease?	☐	☐	
Do you have or have you ever had pain or difficulty urinating, incontinence, kidney trouble, urinary tract infections? If so please explain.	☐	☐	

Name: _____ DOB: _____

	Yes	No	Comments
Do you have joint pain, stiffness, swelling, arthritis, or rheumatism?	☐	☐	
Do you have any numbness or tingling? If so please explain.	☐	☐	
Do you have or have you ever had a stroke?	☐	☐	
Do you have or have you ever had Headaches?	☐	☐	
Have you ever been unconscious?	☐	☐	
Do you have or have you ever had Epilepsy or Seizure disorder?	☐	☐	
Do you have or have you ever had hives or skin rash?	☐	☐	
Do you have or have you ever had Sinus trouble?	☐	☐	
Are you taking birth control pills?	☐	☐	
Are you or could you be pregnant?	☐	☐	
Are you nursing?	☐	☐	
Number of pregnancies	☐	☐	
Have you ever had any Sexually transmitted disease?	☐	☐	
Do you have or have you ever had Infertility?	☐	☐	
Are you nervous	☐	☐	
Do you cry a lot	☐	☐	
Are you depressed	☐	☐	
Are you anxious	☐	☐	
Are you easily irritated	☐	☐	
Do you smoke? If so how much.	☐	☐	
Do you drink alcohol? If so how much?	☐	☐	

List 5 goals you want to achieve from Physical Therapy:

Next Doctor's Appointment: _____

_____ _____ / _____ / _____

Signature Date

_____ _____ / _____/ _____

Therapist Signature Date