Cape Coastal PT

Orthopedic & Sports Physical Therapy

Medical Information Questionnaire

Name: _____ Date: _____

The purpose of this questionnaire is to assist us in providing you quality care by obtaining a better understanding of your complete medical status. Your therapist will answer any questions you may have regarding this questionnaire or your condition during your evaluation. Remember, all information reported below is part of your confidential medical record.

1. Yes No Do you have high blood pressure?
2. Yes No Do you have heart disease?
3. Yes No Do you have a pacemaker?
4. Yes No Do you experience angina (chest pains) at rest or with exertion?
5. Yes No Do you experience shortness of breath?
6. Yes No Do you have lung disease?
7. Yes No Do you have asthma or any known allergies?
8. Yes No Do you have heartburn, stomach, and/or intestinal upset?
9. Yes No Do you have a thyroid condition? Explain:_____
10. Yes No Have you been diagnosed with diabetes?
11. Yes No Have you been diagnosed with cancer? If yes, describe: _____
    _____
12. Yes No Do you have low blood sugar?
13. Yes No Have you experienced recent weight gain/loss?
14. Yes No Do you have osteoporosis?
15. Yes No Have you experienced an increase in frequency or intensity of headaches?
16. Yes No Do you have any unusual joint pain or swelling?
18. Yes No Do you have a history of fractures?
19. Yes No Do you have impaired vision?
20. Yes No Do you have impaired hearing?

OB/GYN

1. Yes No Have you had any complicated pregnancies?
2. Yes No Do you have dysmenorrhea (abnormal menstrual cycles)?
3. Yes No Are you now, or do you have any reason to believe you may be pregnant?

Please list all medications and dosages _____

_____

Please list all surgeries and approximate dates: _____

_____

Please indicate diagnostic tests for this problem: _____

_____

Have you seen anyone else for your current problems? If so, Please list: _____

_____

Signature: _____ **Date:** _____