**Sports and Orthopaedic Therapy Services, LLC Medical History Questionnaire**

**PATIENT**:

Age:

Gender: F M

Ht:\_\_\_ Wt:\_\_\_\_

I certify that the information below is as accurate as I can provide. I understand that it is my responsibility to inform my therapist immediately if there is any significant change in this information or my condition. I am aware that my diagnosis and treatment plan will be discussed and that I have the right to refuse any treatment offered.

Do you have any barriers to learning or communication? Yes No Handed: Right or Left

## Past Medical History Please circle all that apply

Angina / Chest Pain Allergies / Asthma Cancer Cataracts Dizziness / Vertigo

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diabetes | Fibromyalgia | Gout | Heart disease | High Blood Pressure |
| Hearing Loss | Incontinence | Kidney Disease | Lung Disease | Liver Disease |
| Myofascial Pain | Neuropathy | Numbness | Osteoporosis | Osteoarthritis |
| Pins and Needles | Reflux / GERD | Stroke | Spasm | Rheumatoid Arthritis |
| Skin Disease | Trigger points | Ulcers | Surgeries | Pregnancy |

Are you a smoker? Yes

No Are you pregnant? Yes No

Are you allergic to latex? Yes No Do you take blood thinners? Yes No

Are you taking a Statin drug? Yes No Are you taking High Blood Pressure medication? Yes No

## Please list all prescription and over the counter medications you are taking including the dosage, frequency and if by mouth or another method:

***Any falls within the past year? Yes or No If so, how many ? Any falls previous to last year?***

***Any injuries from a fall ?***

***Describe your current symptoms other than pain:***

***Pain Rating:*** /10 ( 0/10 = no pain 10/10 is the worst pain you can imagine )

## Other current symptoms other than pain Please circle all that apply

Changes in bowel or bladder function Change in appetite Depression Dizziness Difficulty Swallowing

Fever / Chills Headache Night Sweats Numbness Nausea / Vomiting Poor Balance or Falls Shortness of Breath Pins and Needles or Tingling Difficulty Sleeping

## Please circle the number which describes you current average level of function:

(Cannot do anything = 0) 0 1 2 3 4 5 6 7 8 9 10 (Able to do everything =10)

What makes your symptoms worse? What makes your symptoms better?

Have you had an X-ray, MRI, EMG or other scan done? Yes When:

No Which:

Have you ever had a cortisone injection or taken pills? Yes No Which: When:

# Signature of patient or responsible person:

**Date: / /**