Dba Integrated Sports Medicine and Physical Therapy, LLC

Medical History Questionnaire

To assist your therapist in completing a thorough evaluation, please provide us with all medical background information. If you do not understand a question, please leave it blank and your therapist will assist you.

Name: ____

Occupation: ____

Leisure Activities: ____

ALLERGIES: List any medications you are allergic to: ____

Are you latex sensitive? ☐ **Yes** ☐ **No** **List any other allergies we should know about:** ____________________

____

Please check any of the following whose care you are under:

☐ Medical Doctor (MD) ☐ Psychiatrist/Psychologist ☐ Other: ____________________
☐ Osteopath ☐ Physical Therapist ____________________
☐ Dentist ☐ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, routine physical, etc.):

____

____

Check if you have **EVER** been diagnosed as having any of the following conditions?

☐ Blood Clots
☐ High Blood Pressure
☐ Circulation Problems
☐ Asthma
☐ Chemical Dependency (i.e. Alcoholism, Prescription Medication)
☐ Diabetes
☐ Multiple Sclerosis
☐ High Cholesterol
☐ MRSA
☐ Rheumatoid Arthritis
☐ Thyroid Problems
☐ Cancer If Yes, describe what kind & treatment ______________________________
☐ Heart Problems If Yes, describe what kind & treatment ______________________________
☐ Kidney Disease If Yes, describe what kind & treatment ______________________________
☐ Tuberculosis
☐ Stroke
☐ Stomach Ulcers
☐ Emphysema/Bronchitis
☐ Epilepsy
☐ Depression
☐ Ehlers-Danlos Syndrome
☐ Hepatitis
☐ Other Arthritic conditions
☐ Osteoporosis

Other ____

Do you have a pacemaker? ☐ Yes ☐ No

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Are you currently pregnant or think you might be pregnant? Estimated Delivery Date? __________ ☐ Yes ☐No

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FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following?

☐ Diabetes
☐ Heart Disease
☐ Kidney Disease
☐ Chemical Dependency (i.e. Alcoholism)
☐ Ehlers-Danlos Syndrome
☐ Cancer
☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
☐ Stroke
☐ Depression
☐ Osteoporosis

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

Date	Reason for Surgery/Hospitalization	Date	Reason for Surgery/Hospitalization
1. _______	______________________________	4._______	______________________________________
2. _______	______________________________	5. ______	______________________________________
3. _______	______________________________	6.________	______________________________________

Please describe all significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date of injury.

Injury	Date	Injury	Date
1) __________________________________	___________	2) __________________________________	__________
3) _________________________________	___________	4) __________________________________	__________
5) _________________________________	___________	6) __________________________________	__________

How much caffeinated coffee or other caffeinated beverage do you drink per day? ___________
How many packs of cigarettes do you smoke a day? _________
How many days per week do you drink alcohol? ____________
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _________
Have you ever taken steroid medications for any reason? _____________
Have you ever taken an anticoagulant? ______________

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

☐ Weight Loss
☐ Weight Gain
☐ Nausea/Vomiting
☐ Fatigue
☐ Weakness
☐ Fever/Chills/Sweats
☐ Numbness or Tingling
☐ Tremors
☐ Seizures
☐ Double Vision
☐ Loss of Vision
☐ Eye Redness
☐ Skin Rash
☐ Problems Sleeping
☐ Sexual Difficulties
☐ Night Sweats
☐ Easy Bruising
☐ Joint/Muscle Swelling
☐ Dizziness/Lightheadedness
☐ Excessive Bleeding
☐ Difficulty Breathing
☐ Regular Cough
☐ Arm/Leg Swelling
☐ Heart Racing in your Chest
☐ Difficulty Swallowing
☐ Heartburn/Indigestion
☐ Constipation/Diarrhea
☐ Blood in Stool
☐ Post Menopause
☐ Problems Urinating (difficulty starting, painful, etc.)
☐ Urinary Incontinence
☐ Blood in Urine
☐ Hearing Problems
☐ Stress at Home or Work

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MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc). You may attach a copy of your own list of medications if available.

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

Medication: ______________________________
Dosage: ______________ Frequency: ________
Route: _______________

Medication: _________________________________
Dosage: ______________ Frequency: ___________
Route: _______________

****During the course of your Physical Therapy, if there are *any changes* (type or dosage) in your medications or supplements, it is important that you notify your therapist!****

Patient Signature: ____________________________________ Date: ______________________

Reviewed with Patient: ________________________________ Date: ______________________