PERSONAL MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ DATE: _____

Please help us to identify your medical needs by carefully completing the following medical history questionnaire.

If you have been diagnosed with any medical conditions from the following list, please circle it, indicate the date of onset and make notations in the current status column.

CONDITION	DATE OF ONSET	CURRENT STATUS
Seizures		
Diabetes		
Hypoglycemia		
High Blood Pressure		
Heart Disease		
Angina/Chest Pain		
Shortness of Breath		
Stroke		
Allergies		
Asthma		
Rheumatic fever		
Hepatitis/Jaundice		
CHRONIC Bronchitis		
Pneumonia		
Emphysema		
Migraine Headaches		
Anemia		
Ulcers/Stomach Problems		
Arthritis/Gout		
Cancer (self or family)		
Vision Problems		
Muscle/Bone Injuries		
Nerve Injuries		

OTHER:_____

_____

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PERSONAL MEDICAL HISTORY QUESTIONNAIRE (CONT.)

1. Are you pregnant?

   _____

2. Please list any current medications; PRESCRIBED and OVER-THE-COUNTER:

   _____
   _____
   _____
   _____
   _____
   _____

3. Has an X-ray, CT scan, MRI, or EMG been performed for this injury? Where/When?

   _____
   _____
   _____

4. Please list any surgeries and dates performed:

   _____
   _____
   _____
   _____
   _____

5. Do you have a pacemaker?

   _____

6. Do you have any metal hardware in your body?

   _____
   _____

7. Are there any other medical concerns we should know about?

   _____
   _____
   _____
   _____

_____ _____

Signature Date

I understand and consent to the treatment plan that has been explained to me by my physical therapist. I reserve the right to refuse treatment in the future.

_____ _____

Signature Date