Surgical Institute of Reading Physical Therapy

Medical History Questionnaire

Name: ________________________________ DOB: _____/_____/________ Age: _________

Family Physician: ________________________________

Your Occupation: ______________________________ Are you working? YES; Full Limited NO

Emergency Contact: ___________________________ Phone: _________________________

Have you had surgery for this injury? YES NO Date of Surgery: ___/___/_____

Is an attorney involved with this injury: Yes No

If so, Case Manager/Lawyer:________________________________ Phone: ___________________

Do you have or have ever had any of the following (check all that apply):

Asthma, Bronchitis, COPD, or Emphysema.	____	Shortness of Breath/Chest Pain	____
Coronary heart disease or angina.	____	Pacemaker.	____
High Blood Pressure.	____	Heart attack/heart surgery.	____
Blood Clot/Embolisms.	____	Stroke/TIA.	____
Joint Replacement.	____	**Diabetes.**	____
Infectious diseases.	____	**Cancer/chemo/radiation.**	____
Arthritis/Swollen Joint.	____	Smoker.	____
Osteoporosis.	____	Severe/Frequent Headaches.	____
Vision/Hearing difficulty.	____	Numbness/Tingling.	____
Dizziness/Fainting.	____	Weight Loss/Energy Loss.	____
Hernia.	____	Epilepsy/Seizures.	____
Incontinence.	____	Bowel/Bladder Problems.	____
Neck Injury/Surgery.	____	Shoulder Injury/surgery.	____
Elbow Injury/Surgery.	____	Back Injury/Surgery.	____
Knee Injury/Surgery.	____	Leg/Ankle/Foot Injury/Surgery.	____
Balance Disorders.	____	Falls.	____

WOMEN ONLY:

Pelvic Inflammatory Disease.	____	Endometriosis.	____
Irregular menstrual cycle.	____	Complicated pregnancy/deliveries	____
Frequent UTIs/Kidney Stones.	____	Are you pregnant?	____

MEDICATIONS (List on the back of this page if needed):

Medication/Supplement Name	Dose	Frequency	How do you take/use?
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin
			By mouth Inject Suppository Rub on skin

Any Drug Allergy? YES NO

If Yes, to what? ____

Allergies to other substances? YES NO

If Yes, to what? ____

Describe the problem for which you seek skilled physical therapy:

____

____

When did the problem begin? Month / Day / Year: ___________________________

What happened? ____

____

Have you had this problem before? YES NO When? Month/Year: _________/_____

Is this a result of a car accident? YES NO

If Yes, please describe the accident/injury: _____________________________________

Pain Rating: (Please rate your pain using the numeric scales below)

Please rate your **current level of pain** on the following scale (circle the appropriate number):

0 1 2 3 4 5 6 7 8 9 10

NONE I------------------- MILD ---------------------I I--------------------- MODERATE ---------------------I I--------------------- SEVERE ---------------------I

Please rate your worst level of **pain in the last 3 days** on the following scale (circle the appropriate number):

0 1 2 3 4 5 6 7 8 9 10

NONE I------------------- MILD ---------------------I I--------------------- MODERATE ---------------------I I--------------------- SEVERE ---------------------I

Please rate your best level of **pain in the last 3 days** on the following scale (circle the appropriate number):

0 1 2 3 4 5 6 7 8 9 10

NONE I------------------- MILD ---------------------I I--------------------- MODERATE ---------------------I I--------------------- SEVERE ---------------------I

Patient/Guardian Signature: _________________________________ Date: ___/___/_____

Physical Therapist Signature: _________________________________ Date: ___/___/_____