Health History Questionnaire **Name:** **DOB:**

Thank you for choosing FIT Physical Therapy for your physical therapy needs. Please fill out this questionnaire below to the best of your ability so that we may provide you the best and safest care.

Tell us why you are here today: ____

Circle yes or no if you have or have had any of the listed conditions or treatment for any of these conditions in your lifetime and write the approximate year you received treatment if applicable.

Cancer:

Lung	Yes No	Breast	Yes No
Prostate	Yes No	Colon	Yes No
Skin	Yes No	Bone	Yes No
Leukemia	Yes No	Lymphoma	Yes No
Other:			

Infections:

UTI/Urinary Tract	Yes No	Bladder/Kidney	Yes No
Pneumonia/Lungs/TB	Yes No	Bone/Joint	Yes No
Pelvic Organs	Yes No	MRSA/Staph	Yes No
Other:			

Cardiac/Heart Conditions:

Heart Attack	Yes No	Angina/Chest Pain	Yes No
Heart Valve/Murmurs	Yes No	Heart Surgery/Stents	Yes No
Bypass Surgery	Yes No	High Blood Pressure	Yes No
Irregular Heart Beat	Yes No	Heart Failure	Yes No
Other:			

Circulation/Lungs:

Blood Clots/DVTs	Yes No	Arterial Blockage of Legs/Arms	Yes No
Aortic Aneurysms	Yes No	Surgery for Aneurysm	Yes No
Peripheral Vascular Disease (PVD)	Yes No	Sickle Cell/Clotting Disorders	Yes No
Anemia	Yes No	Strokes/MiniStrokes/CVA	Yes No
Asthma	Yes No	COPD/Emphysema	Yes No
Shortness of Breath	Yes No	Other:	

Endocrine Issues:

Hypo/Hyperthyroid	Yes No	Diabetes	Yes No
Hypoglycemia	Yes No	Metabolic Syndrome	Yes No
Other:			

Neurological:

Multiple Sclerosis (MS)	Yes No	ALS	Yes No
Seizures/Epilepsy	Yes No	Headaches	Yes No
Parkinson's/ PSP	Yes No	Vertigo/Syncope	Yes No
Guillane Barre	Yes No	Myasthenia Gravis	Yes No
Alzheimer's/Dementia	Yes No	Other:	

Orthopedic Conditions:

Osteoarthritis	Yes No	Rheumatoid Arthritis	Yes No
Gout	Yes No	Ankylosing Spondylitis	Yes No
Osteoporosis	Yes No	Joint Replacement Hip/Knee/Ankle	Yes No
Joint Replacement Shoulder/Elbow/Hand	Yes No	Other orthopedic surgeries or fractures	Yes No
Ligament Injuries	Yes No	Back/Neck Surgery	Yes No
Other/List:			

Kidney/Liver/GYN/Urinary:

Abdominal Surgeries	Yes No	Hepatitis	Yes No
Urinary Retention/Frequency	Yes No	Endometriosis	Yes No
Hysterectomy	Yes No	Prostate Enlargement	Yes No
Live Births/C-sections	Yes No	Other/List:	

Psychological:

Depression	Yes No	Anxiety	Yes No
Bipolar	Yes No	Schizophrenia	Yes No
Other:			

In the past month, have you experienced any of the following:

Loss of Bladder/Bowel control	Yes No	Unintentional Weight loss	Yes No
Numbness/Tingling anywhere in the body	Yes No	Fevers/Night Sweats	Yes No
Night Pain	Yes No	Dizziness	Yes No
Falls	Yes No	Chest Pain	Yes No
Short of Breath	Yes No	Fatigue/Weakness	Yes No
Difficulty Swallowing	Yes No		

Life Style:

Smoker: Current or past	Yes ____ Packs per day No	When did you quit? _____
Alcohol: Current or past	Drinks per day____per week___	Social drinker None
Recreational Drugs: Current/Past	Type:	How Often?
Caffeine: Type	Coffee/Tea/Soda	How many cups a day? _____

Please list anything else in regards to your medical history that we need to know to provide safe and thorough care.

____

____

____

Medications

In the past 4 weeks, have you taken any over the counter medications listed here?

Advil/Ibuprofen	Yes NO	Aleve/Naproxen	Yes NO
Aspirin	Yes NO	Tylenol/Acetometophin	Yes NO
Antacids	Yes NO	Laxatives	Yes NO
Cold Medications	Yes NO	Antihistamines/Allergy	Yes NO
Zantac/Pepsid/Tagamet	Yes NO	Multivitamin	Yes NO
Supplements/Herbals	Yes NO	Other:	

Please list all your medications and dosage including herbals, supplements, vitamins, and over the counter medications:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Patient Signature:____**Date:**_____________________

Therapist Signature:____**Date:**_____________________