EAST VALLEY PHYSICAL THERAPY MEDICAL HISTORY QUESTIONAIRE

NAME _____ DATE _____

DATE OF BIRTH _____ HEIGHT _____ft _____in WEIGHT _____ lbs

PRIMARY REASON FOR YOUR VISIT: _____

DATE OF ONSET/INJURY:_____ IS THIS RELATED TO: ☐ WORK ☐ AUTO ☐ N/A

DATE OF SURGERY: _____ TYPE OF SURGERY: _____

MEDICATION	DOSE	TIMES PER DAY
☐ SEE ATTACHED		

ALLERGIES: ☐ LATEX ☐ ADHESIVE TAPE ☐ OTHER TYPES OF TAPE

PLEASE LIST ANY ALLERGIES TO MEDICATIONS INCLUDING CORTISONE:

_____

_____

☐ NO KNOWN ALLERGIES

HAVE YOU HAD ANY MEDICAL CONDITONS WE SHOULD BE AWARE OF, INCLUDING BUT NOT LIMITED TO: (MARK ALL THAT APPLY)

☐ DIABETES ☐ HEART CONDITION ☐ CVA/STROKE

☐ CANCER ☐ SEIZURE DISORDER ☐ PULMONARY(LUNG)

☐ PACEMAKER ☐ CURRENTLY PREGNANT ☐ BLOOD PRESSURE

☐ BOWEL/BLADDER ☐ JOINT REPLACEMENT ☐ NONE

☐ INDWELLING STIMULATOR / PAIN PUMP / INSULIN PUMP

☐ OTHER _____