ESTERSON & ASSOCIATES PHYSICAL THERAPY MEDICAL HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to help us understand your health status. This form is considered part of your medical record.

Name: ____________________

Date of Last General Health Check-up _____/_____/_____ Occupation: ____________________

Height____________ **Weight**____________

Have you had Surgery for this Injury? YES NO Type of Surgery/Dates: ____________________

Is an Attorney Involved in this Case? YES NO Attorney Name: ____________________

Please List Any Prescription or Non-Prescription Medications You Currently Take **(With Dosages/Frequency)**

____

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____

Please answer the following questions:

Yes/No **Are you pregnant?**

Yes/No **Do you smoke?**

Yes/No **Do you have a pacemaker? Or other implantable device?**

Yes/No **Do you have any allergies? If yes, please list**____________________

Yes/No **Have you had any prior related or unrelated surgeries? If yes, please year of surgery and type of surgery**____________________

Yes/No **Do you have an infectious disease? (Hepatitis, HIV, AID, etc…). If yes, please list**____________________

Please check if you now have, or have ever had, any of the following?

_______ Asthma, Bronchitis or Emphysema (circle)
_______Shortness of Breath
_______ Chest Pain or Angina
_______Coronary Heart Disease
_______High Blood Pressure
_______Heart Attack/Heart Surgery
_______Blood Clot/Emboli
_______Stroke/TIA
_______Diabetes
_______Pins or Metal Implants _______
_______Joint Replacement (list joint)_______
_______ Recent or Sudden Loss of Bladder/Bowel Control
_______Cancer/Chemotherapy/Radiation. Location:________
_______Arthritis/Swollen Joints
_______Osteoporosis
_______Osteopenia
_______Injury to any of the following (Please check below):
____Neck; _____Shoulder; ____ Elbow/wrist/hand; ____Back; ____Hip; ____Knee; _____ Ankle/Foot

________Severe or Frequent Headaches
________Vision or Hearing Difficulty
________Numbness or Tingling
________Dizziness or Fainting
________Weakness
________Weight loss/Energy loss
________Hernia
________Epilepsy/Seizures
________Hyper/Hypo Thyroidism
________Incontinence
________Complicated Pregnancies/Deliveries
________Autoimmune Condition: ____________
________ Multiple Sclerosis
________Parkinson's
________Fibromyalgia
________Sleeping Problems/Difficulty

Any other diseases/conditions you feel we should know about?____________________

Patient Signature: ____________________ Date:____________

Therapist Initials __________ Date: ____________

EMAIL ADDRESS:____________________
(For automatic appointment reminders only)

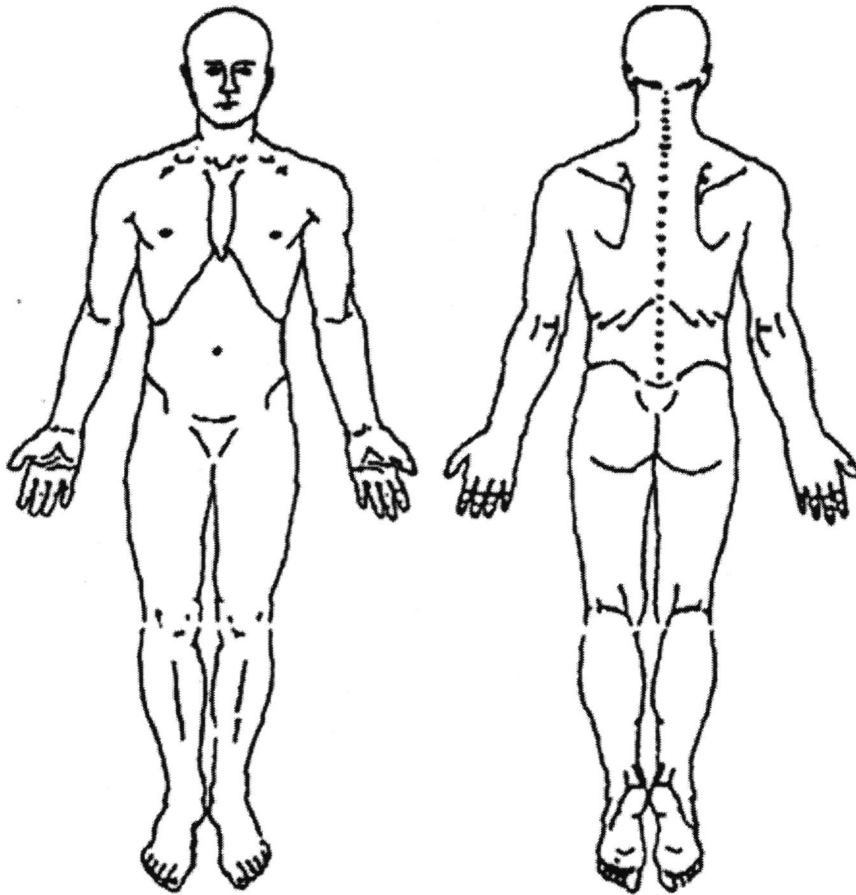
PLEASE CONTINUE ON THE OTHER SIDE OF THE PAGE

My pain can be described as: (please circle all that apply):

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Pain (please circle where you would rate your pain intensity):

0 (No Pain)---------------------------------5------------------------------------10 (maximum)



PLEASE INDICATE BY SHADING IN THE DIAGRAM

WHERE YOU ARE HAVING YOUR SYMPTOMS