FABIAN
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Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your session. This form is considered part of your medical record:

Name:_____Birthdate:___/___/___

Present condition

What symptoms do you have?:

_____

Date of injury or onset of symptoms:_____

How did this injury occur?:_____

Do you have pain ?: No___if yes mark on this line how much pain do you have

(0= no pain , 10= extreme pain)

I_____I
0 10

My pain could be described as (please check all that apply):
Constant___ Intermittent___ Sharp___ Dull___ Aching___ Stabbing___
Numbness___ Pins & needles___
Indicate the area of pain:_____

Do any of these activities increase your pain or symptoms?
Walking ___ Standing ___ Sitting___ Lying down___ Sleeping ___ Reaching ___
Bending down ___any other activity not listed :_____
_____

Are you currently taking any medications?: No___if yes please list them:_____
_____

Do you take any supplements?: No__if yes please list them and how much:____
_____

Have you had any tests taken for this injury? No___If yes:
please check all and list any not marked : CT scan:___MRI___X-ray___Myelogram___Emergency Room Care ___
EMG_____

Do you have or ever had any of the following problem?

Asthma, Bronchitis, Emphysema	No___	Yes___
Do you feel shortness of breath or chest pain ?	No___	If Yes , do you ever feel it lying down or resting? _____
Coronary heart disease or Angina	No___	Yes___
Do you have a pacemaker?	No___	Yes___
High Blood Pressure	No___	Yes___
Heart Attack/ Heart Surgery	No___	If Yes , when and what type of surgery? _____
Blood clot/ Emboli	No___	Yes___
Stroke/TIA	No___	If Yes, when?_____
Allergies	No___	Yes___
Pins and metal implants	No___	If Yes,where?_____
Joint replacement	No___	If Yes, what part of the body and when?_____
Diabetes	No___	If Yes, do you take medication or insulin shots?_____
Infectious diseases (HIV, Hepatitis A,B,C,Tuberculosis)	No___	If Yes, what type?_____
Cancer	No___	If Yes, what type, did you have chemotherapy, radiation or surgery, when?_____
Arthritis, swollen joints	No___	If Yes, what type, what joints?_____
Osteoporosis	No___	Yes___
Sleeping problems	No___	If Yes, how many hours do you sleep?_____

Do you wake up during the night? No___ If Yes, why?_____
Do you smoke? No___ If Yes, how many cigarettes a day and how long have you been smoking?_____
Latex sensitivity/allergy No___ Yes___
Severe or frequent headaches No___ If Yes,which part of your head hurts?_____
Vision or hearing difficulty No___ Yes___
Numbness or tingling No___ If Yes, what part of the body?_____
Dizziness/Fainting No___ Yes___
Weakness No___ Yes___
Weigh loss/ Energy loss No___ Yes___
Hernia No__ If Yes, what part of the body an did you have surgery, when?_____
Epilepsy/ Seizures No___ If Yes, when was the last one?_____
Thyroid/Goiter No___ Yes___
Incontinence No___ If Yes, do you have a problem with your bowels or bladder?_____
Multiple Sclerosis No___ Yes___
Parkinson's No___ Yes___
Vertigo (room spinning) No___ Yes___
Do you have problems with your balance? No___ Yes___
Do you have difficulty walking? No___ If Yes, how far can you walk?_____
Do you fall often? No___ If Yes, how often?____
Do you feel uninterested in things or depressed? No___ Yes___

What kind of exercise do you do and how many minutes and how often?_____
List all the diseases your blood relatives had:_____
_____
How did your parent pass away?_____
List all surgeries, accidents, diseases you ever had ?_____
_____
List all the problems, diagnoses a doctor ever told you that you have_____
_____
Do you feel under a lot of stress ? No___ If Yes, what kind of stress do you have in your life?
_____
Do you think that any significant event happened that might be effecting your health ?
No___ If Yes, what is it ?_____
Do you live alone? No___ Yes___
Do you have relatives on the island ? No___ Yes___
What are your goals and expectations from your physical therapy treatments? What would you like to achieve?
_____
_____
_____
_____
_____

For women only:
Do you have or ever had any of the following?
Pelvic inflammatory disease No___ Yes___
Irregular menstrual cycle No___ Yes___
Complicated pregnancies No___ Yes___
Endometriosis No___ Yes___
Are you pregnant? No___ Yes___

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

Therapist's initials:_____ Date:___/___/___