Santiago
Physical Therapy, Inc.
Medical History Questionnaire

Name (Print): _____ Date: _____

Present Illness:

For what condition or symptoms are you being seen at this time?_____

_____

When did this condition begin (date of injury or onset of symptoms)? _____

What treatment have you already received?_____

_____

Has this problem occurred in the past? _____

Past Medical History: Please indicate whether you have had any of the following conditions: (please circle)

Heart Disease: Congestive Heart Failure High Blood Pressure Heart Attack (MI)
Atherosclerotic Disease (CAD) Angioplasty Valvular Disease
Stents Arrhythmia Angina
Coronary Artery Bypass Graft (CABG)
Comments: _____

Lung Disease: Chronic Obstructive Pulmonary Disease (COPD) Asthma
Emphysema Smoker Recent Pneumonia
Comments:_____

Vascular Disease: Peripheral Arterial Disease Stroke/TIA Chronic Bronchitis
Acquired Respiratory Distress Syndrome (ARDS) Hypertension
Diabetes Taking Blood Pressure Meds
Comments: _____

General Medical Conditions: Allergies Osteoporosis Arthritis (Rheumatoid/Osteo)
Neurological Disease (i.e. MS or Parkinson's) Headaches
Hepatitis/AIDS Depression Anxiety or Panic Disorder
Prior Surgery(s) Previous Accidents Incontinence
Sleep Dysfunction Prosthesis/Implants Cancer
Epilepsy/convulsions Tuberculosis Anemia
Hernia Thyroid Disorders Venereal Disease
Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
Visual Impairment (cataracts, glaucoma, macular degeneration)
Back Pain (neck, low back, degenerative disc disease, spinal stenosis)
Kidney, Bladder, Prostate or Urination Problems
Hearing Impairment very hard of hearing, even with hearing aids.

OVER…>

Comments: _____

_____

_____

Surgery: Please list all previous operations and indicate the approximate year or your age at the time of the procedure: _____

_____

_____

Fractures: Please list fractures and other serious injuries, the date and type: _____

_____

_____

Allergies: _____

Current Medications: (provide a list for us to copy if you wish)_____

_____

Home Status: I am a caretaker for someone in my home Y N
I have a live in caretaker or someone who comes to the house on a regular basis to help me Y N
I am able to drive, attend social events, and care for myself Y N
I have fallen in the last year Y N
There are others who live with me Y N

Comments:_____

_____

Family History: Has any blood relative ever had any of the following (please circle):

Cancer	Heart Disease	Arthritis	Tuberculosis	Gout
High Blood Pressure	Bleeding Tendency	Diabetes	Stroke	

Comments: _____

_____

_____ _____

Patient's Signature **Date**

Physical Therapist Initials/Date: _____/_____