Osprey Physical Therapy & Sports Medicine

Soaring Together In Your Health and Wellness

Medical History Questionnaire

Name:_____ Date:_____

Please check “yes” or “no” for each question below. For any “yes” answer, please explain. Thank you!

Yes	No		Yes	No	
		Diabetes			Allergies to latex/rubber
		High blood pressure			Pacemaker
		Heart disease			Implants including metal
		Stroke			Night sweats
		Cancer or tumors			Changes in bowel/bladder habits
		Respiratory problems			Unusual fatigue or weakness
		Disorder affecting immune system			Frequent urination
		Headaches			Recent loss of weight
		Dizziness			Nausea or vomiting
		Seizures			Fever and chills
		Vision problems			Easy bruising or bleeding
		Arthritis or joint problems			Ever been hospitalized
		Cramping			Changes in memory or cognition
		Osteoporosis/osteopenia			Currently pregnant?

Are you currently taking any medications, prescription or over the counter? Yes_____ No_____

If yes, please list any medications you are currently taking here:_____

_____

Please list any surgeries you have had in the past:_____

Have you ever had physical therapy in the past? Yes_____ No_____

If yes, what for?_____

_____

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