UNIVERSITY OF MARYLAND • UNIVERSITY HEALTH CENTER

Physical Therapy Unit Medical History Questionnaire

Name _____ Date _____

Address _____

State _____ Zip _____ Phone Number _____

SSN _____ Occupation _____

Age _____ Describe Physical Demands (ex.: sitting, standing, etc.):

Weight _____ _____

Height _____ _____

Medical Insurance Company _____

_____

PAST MEDICAL HISTORY

Circle, Answer, and Explain any YES responses.

High Blood Pressure	Yes	No	Pacemaker	Yes	No
Heart Attack	Yes	No	Cancer	Yes	No
Heart Condition	Yes	No	Strokes	Yes	No
Diabetes	Yes	No	Arthritis	Yes	No
Dizzy Spells	Yes	No	Metal Implants	Yes	No
Surgeries (orthopedic)	Yes	No	Seizures	Yes	No
Fractures	Yes	No	Circulation Problems	Yes	No
Back Problems	Yes	No	Date of Injury	Yes	No
Are you pregnant?	Yes	No			

Describe YES answers: _____

_____

CURRENT MEDICAL HISTORY

Diagnosis: _____

Orthopedic Physician _____

Physician who referred you to Physical Therapy _____

When is your next appointment with the referral doctor? _____

If you had x-rays or other tests, describe and give dates _____

Exercise level (non-active) 1 2 3 4 5 6 7 8 9 10 (very active)

Have you had Physical Therapy for this condition? Yes No

Describe type and results of treatment _____

_____

_____