The Physical Therapy Place

Orthopedics and Women's Health

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Name:		**Date:**
Date of Birth:	**Height:**	**Male/Female**
Occupation:		**Hobbies:**

Have you or an immediate family member ever been diagnosed with:

	Family	You
Cancer	No/Yes	No/Yes
Low/High Blood Pressure	No/Yes	No/Yes
Diabetes	No/Yes	No/Yes
Heart Disease	No/Yes	No/Yes
Angina/chest pain	No/Yes	No/Yes
Stroke	No/Yes	No/Yes
Arthritis	No/Yes	No/Yes

Do you have a history of:

Nausea/vomiting	No/Yes
Fever/Chills/Sweats	No/Yes
Unexplained weight change	No/Yes
Numbness or tingling	No/Yes
Muscular weakness	No/Yes
Fainting spells	No/Yes
Dizziness	No/Yes
Night pain	No/Yes
Bowel or bladder changes	No/Yes
Headaches	No/Yes

Have you had or do you experience:

Shortness of breath	No/Yes
Allergies	No/Yes
Asthma	No/Yes
Bronchitis	No/Yes
Kidney disease/stones	No/Yes
Polio	No/Yes
Emphysema	No/Yes
Anemia	No/Yes
Rheumatic fever	No/Yes
Ulcers	No/Yes

Have you had any recent illness, including respiratory infections or urinary tract infections?	No/Yes
Do you smoke?	No/Yes If Yes, how many packs a day? ____ How long have you smoked? ______
Do you drink alcohol?	No/Yes How many drinks each day________ Each week_______
Do you drink/consume caffeine?	No/Yes How often?
How often to you feel stress is a significant factor in your life? *(Circle One)*	Never Seldom Occasionally Regularly Always
Do you exercise regularly?	No/Yes. If Yes, what type and how often?

Have you had any surgery? Please list.

Please list any medications you may be taking: