STEEL VALLEY PHYSICAL THERAPY
HEALTH HISTORY QUESTIONNAIRE

NAME: _____ D.O.B. _____

Have you ever had or been treated for the following:

	YES	NO
DIABETES TYPE_____	____	____
HEART PROBLEMS/DISEASE LIST_____	____	____
LUNG/BREATHING PROBLEMS LIST_____	____	____
STROKE DATE_____	____	____
STOMACH/INTESTINAL PROBLEMS LIST_____	____	____
RASHES/SORES/LUMPS LIST_____	____	____
ARTHRITIS TYPE_____	____	____
CANCER TYPE_____ DATE_____	____	____
THYROID DISEASE	____	____
FEVER	____	____
HIGH BLOOD PRESSURE (HTN)	____	____
CHEST PAIN/TIGHTNESS	____	____
MI/HEART ATTACK	____	____
SHORTNESS OF BREATH	____	____
TUBERCULOSIS	____	____
BOWEL/BLADDER CHANGES	____	____
PAIN/BURNING DURING URINATION	____	____

	YES	NO
NEUROPATHY	____	____
EPILEPSY/SEIZURE	____	____
BALANCE PROBLEMS	____	____
TREMORS/SHAKING	____	____
DIZZINESS/FALLS	____	____
POOR CIRCULATION	____	____
RECENT WEIGHT LOSS/GAIN	____	____
FREQUENT HEADACHES/MIGRAINES	____	____
BLURRED VISION	____	____
RHEUMATIC FEVER	____	____
PRIOR FRACTURES	____	____
OSTEOPOROSIS/OSTEOPENIA	____	____
GOUT	____	____
BONE/JOINT PROBLEMS	____	____
BLOOD TRANSFUSION	____	____
HIV/AIDS	____	____
BLOOD CLOTS/PHLEBITIS	____	____
LIVER PROBLEMS	____	____
DRUG/ALCOHOL PROBLEMS	____	____
PSYCHIATRIC PROBLEMS	____	____
LATEX ALLERGY	____	____

MEDICATIONS (NAME AND DOSAGE):

1. _____
2. _____
3. _____
4. _____

PRIOR SURGERIES (TYPE AND DATE):

1. _____
2. _____
3. _____
4. _____