AHNEW
PHYSICAL THERAPY

HEALTH HISTORY QUESTIONNAIRE

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

SOCIAL HEALTH HABITS

☐ Do you smoke tobacco? ☐ No ☐ Yes Amount _____
☐ Do you drink alcohol? ☐ No ☐ Yes Amount _____
☐ Do you use recreational drugs? ☐ No ☐ Yes Amount _____
☐ Do you exercise? ☐ No ☐ Yes Minutes per day? _____Days per week? _____
If Yes, describe exercise/ activity_____

EMPLOYMENT/WORK

Work Status:

☐ Unemployed ☐ Working Full-Time ☐ Working Light Duty ☐ Student
☐ Homemaker ☐ Working Part-Time ☐ Disabled ☐ Retired

GENERAL HEALTH STATUS

Please rate your Health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Major Life Changes (in the past year):

☐ None ☐ Death in Family ☐ New Job ☐ Divorce ☐ Move

FAMILY HISTORY

Please check if anyone in your family has or has had any of the following:

☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Psychological problems
☐ Pulmonary/Lung Disease ☐ Diabetes ☐ Arthritis ☐ Stroke
☐ Osteoporosis ☐ Allergies ☐ Hearing Loss ☐ Vertigo
☐ Balance Problems ☐ Other

PAST MEDICAL HISTORY

Please check all that apply:

☐ No History ☐ Diabetes ☐ Kidney Disease ☐ Parkinson's Disease
☐ AIDS ☐ Emphysema ☐ Liver Disease ☐ Prostate Disease
☐ Allergies ☐ Epilepsy/Seizures ☐ Low Blood Pressure ☐ Skin Disorders
☐ Arthritis ☐ Fibromyalgia ☐ Lung Disorder ☐ Sleep Disorders
☐ Blood Disorders ☐ Glaucoma ☐ Lyme's Disease ☐ Stroke
☐ Broken Bones ☐ Heart Attack ☐ Macular Degeneration ☐ Thyroid Disorders
☐ Chronic Fatigue Syndrome ☐ Hepatitis ☐ Migraines ☐ Repeated Infections
☐ Circulation Problems ☐ Head Injury ☐ Muscular Dystrophy ☐ Reoccurring Vertigo
☐ Cancer ☐ High Blood Pressure ☐ Multiple Sclerosis ☐ _____
☐ Cystic Fibrosis ☐ High Cholesterol ☐ Osteoporosis ☐ _____
☐ Depression ☐ Genetic Disease ☐ Pacemaker ☐ _____

FOR WOMEN ONLY

☐ Pelvic Inflammatory Disease ☐ No ☐ Yes ☐ Trouble with period ☐ No ☐ Yes
☐ Complicated Pregnancies ☐ No ☐ Yes ☐ Currently Pregnant ☐ No ☐ Yes
☐ Endometriosis? ☐ No ☐ Yes
☐ Increase in current symptoms with hormonal changes? ☐ No ☐ Yes
☐ Other _____

SURGICAL HISTORY

Please list any surgeries you have had, and if known, include dates:

☐ NO surgeries to date

Surgery: _____ Month: _____ Year _____

Surgery: _____ Month: _____ Year _____

Surgery: _____ Month: _____ Year _____

SYMPTOM CHECKLIST

Within the last year, have you had any of the following symptoms (check all that apply):

☐ NO Symptoms
☐ Bowel problems
☐ Chest Pain
☐ Chills
☐ Cough (persistent)
☐ Concentration problems
☐ Difficulty driving
☐ Difficulty walking
☐ Difficulty sleeping
☐ Dizziness
☐ Excessive sweating
☐ Fatigue
☐ Fever
☐ Foggy headedness
☐ Headaches
☐ Hearing loss
☐ Heart palpitations
☐ Joint pain or swelling
☐ Lethargy
☐ Loss of appetite
☐ Loss of balance
☐ Motion sickness
☐ Nausea/Vomiting
☐ Numbness in arms/legs
☐ Pain at night
☐ Pressure in your ears
☐ Shortness of breath
☐ Vision Problems
☐ Syncope (passing out
☐ Tinnitus (noises in your ear)
☐ Tremors: Type:_____
☐ Urinary problems: _____
☐ Weakness in arms/legs
☐ Weight gain (unexplained)
☐ Weight loss (unexplained)
☐ Dizziness with loud noises
☐ Dizziness with physical exertion
☐ Other _____

DIAGNOSTIC TESTS/MEASURES

Within the last year, have you had any of the following tests (check all that apply):

☐ NO diagnostic tests
☐ Angiogram
☐ Arthoscopy
☐ Biospy
☐ Blood test
☐ Bone Scan
☐ Other:_____
☐ Bronchoscopy
☐ CT Scan
☐ Ultrasound
☐ Echocardiogram
☐ EKG
☐ EEG
☐ Hearing tests
☐ Mammogram
☐ MRI
☐ Pap Smear
☐ EMG/Nerve Conduction
☐ ENG
☐ Pulmonary Function Test
☐ Speech/Language Evaluation
☐ Stool Test
☐ Urine Test
☐ X-ray

CURRENT MEDICATIONS

Please indicate all medications or allergies:

NON-PRESCRIPTION Medications:

- ☐ No Medications
- ☐ Advil/Alleve
- ☐ Decongestants
- ☐ Excedrin
- ☐ Decongestants
- ☐ Excedrin
- ☐ Herbal Supplements
- ☐ Ibuprofen/Naproxen
- ☐ Antihistamine
- ☐ Aspirin
- ☐ Motrin
- ☐ Vitamins/Minerals
- ☐ Tylenol
- ☐ Other:_____

PRESCRIPTION Medications:

- ☐ No Medications
- ☐ See attached list
- ☐ HTN Medications ☐ No ☐ Yes - Please list: _____
- ☐ Other:_____

ALLERGIES:

- ☐ Drug allergies ☐ No ☐ Yes - Please list: _____
- ☐ Airborne allergies ☐ No ☐ Yes - Please list: _____

Are you receiving any treatment for the above stated allergies? If yes, please describe below.

_____

_____

FOR OFFICE USE ONLY

PRECAUTIONS

- ☐ Fall risk
- ☐ HTN
- ☐ Hypotension
- ☐ Contraindications:
- ☐ Constitutional S&S:
- ☐ Other_____

Notes: _____

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