Jordan Valley Medical Center
Physical Therapy Department
Medical History Questionnaire

Patient Name: _____ Date: _____

1. Do you have any conditions or past injuries, which would limit the range of motion of your muscles, bone joints, or spine, which may be aggravated by exercise? Yes _____ No _____

2. Have you ever had these symptoms before? Yes _____ No _____
   Previous injuries related to your current symptoms: _____

3. Have you had a related surgery? Yes _____ No _____ If yes, please provide date(s):
   ___/___/___, ___/___/___, ___/___/___

4. Do you smoke? Yes _____ No ____If yes, number of packs per day? _____

5. Do you drink alcohol? Yes _____ No _____ If yes, number of drinks per week? _____

6. Have you ever been treated by a physical or occupational therapist? Yes _____ No _____

7. do you have or have you had any of the following:

___ Diabetes
___ Chest pain/angina s
___ High Blood Pressure
___ Heart Disease
___ Heart Palpitations
___ Pacemaker
___ Headaches
___ Kidney Problems
___ Are you pregnant?
___ Cancer
___ Abnormalities
___ Hypoglycemia
___ Bowel/Bladder Abnormalities
___Urine Leakage
___ Asthma/Breathing Difficulties
___ Liver/Gallbladder Difficulties
___ Smoking
___ Other: _____
___ Motion Sickness
___Allergies to Aspirin
___ Allergies to Heat
___ Allergies/Poor Tolerance to Cold
___ Other Allergies
___ Special Diet Guidelines
___ Hernia
___ Seizures
___ Metal Implants
___ Dizziness/Fainting
___ Recent Fractures
___ Surgeries
___ Skin Abnormalities
___ Sexual Dysfunction
___ Nausea/Vomiting
___ Ringing in your ears
___ Rheumatoid Arthritis

If yes on any of the above, please briefly explain and give approximate date:

_____
_____
_____

8. Is there any other information regarding your past medical history that we should know about?

_____
_____

Signature: _____ Date: _____

Relationship to Patient (if minor): _____