

Name _____

**UW SPORTS MEDICINE PHYSICAL THERAPY CLINIC
PATIENT HISTORY QUESTIONNAIRE**

Welcome to the UW Sports Medicine Physical Therapy Clinic. Please take a few moments to complete this questionnaire and bring it with you to your first appointment. This information will assist us in providing you with quality care. All information is kept confidential.

What is the primary problem you would like your physical therapist to address?

How long have you had this problem? _____

What activities/movements increase your pain? _____

What things help to decrease your pain? _____

What is your occupation? _____

Have you ever been diagnosed as having any of the following conditions?

- | | | |
|-----|----|---------------------------------------|
| Yes | No | Cancer |
| Yes | No | Heart problems |
| Yes | No | Circulation problems |
| Yes | No | High blood pressure |
| Yes | No | Asthma |
| Yes | No | Emphysema/Bronchitis |
| Yes | No | Chemical dependency (e.g. alcoholism) |
| Yes | No | Thyroid problems |
| Yes | No | Diabetes |
| Yes | No | Multiple sclerosis |
| Yes | No | Rheumatoid arthritis |
| Yes | No | Other arthritic conditions |
| Yes | No | Depression |
| Yes | No | Hepatitis |
| Yes | No | Tuberculosis |
| Yes | No | Stroke |
| Yes | No | Kidney disease |
| Yes | No | Anemia |
| Yes | No | Epilepsy |
| Yes | No | Other (please list) |

Please list any surgeries or other conditions for which you have been hospitalized.

Date Surgery/reason for hospitalization

Please list any injuries for which you have been treated (include fractures, strains, dislocations)

Date Injury

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following conditions?

Yes	No	Diabetes
Yes	No	Tuberculosis
Yes	No	Heart disease
Yes	No	High blood pressure
Yes	No	Stroke
Yes	No	Kidney disease
Yes	No	Cancer
Yes	No	Arthritis
Yes	No	Anemia
Yes	No	Epilepsy

Which of the following medications have you taken in the last week? (circle answers)

Aspirin
Tylenol
Ibuprofen/Advil/Motrin
Laxatives
Decongestants
Antihistamines
Antacids
Vitamins/mineral supplements
Other _____

Please list any prescription medication you are currently taking. _____

Do you smoke? Yes No

Have you recently noticed any of the following?

Yes	No	Weight loss
Yes	No	Weight gain
Yes	No	Nausea/vomiting
Yes	No	Fatigue
Yes	No	Weakness in your arms or legs
Yes	No	Fever/chills/sweats
Yes	No	Numbness or tingling
Yes	No	Dizziness
Yes	No	Chest pain

Address: _____

Phone: (W) _____ (H) _____