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

____

____

____

-OVER-

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)________________________