Date:

Cornerstone Physical Therapy
Medical History Questionnaire

Name: _____ DOB/Age: _____

Height: _____ Weight: _____Onset/Injury Date: _____

Occupation/Employer: _____ ☐ Full Time ☐ Part Time

Job Duties: _____ ☐ Light Duty

Referring Physician: _____ Primary Physician: _____

Sports/Recreational Activities/Hobbies: _____

Please provide name of any of the following healthcare professionals you have seen within the last **year**:

Medical Doctor: _____ Psychiatrist/Psychologists: _____

Chiropractor:_____ Occupational Therapist: _____

Dentist: _____ Physical Therapist: _____

OTHER: _____

If you have seen any of the above mentioned **within the last year**, please describe for what reason: _____

_____

_____

Review of Symptoms

Symptom	Y	N	Explain	Symptom	Y	N	Explain
Fever	Y	N		**Genitourinary** *(kidney/bladder)*			
Weight Loss	Y	N		Incontinence	Y	N	
Eye Related				Pain	Y	N	
Loss of Vision	Y	N		**Musculoskeletal** *(muscle/skeleton)*			
Blurred Vision	Y	N		Surgery	Y	N	
Visual Difficulty Driving	Y	N		Muscle Pain	Y	N	
Problems w/Night Vision	Y	N		Joint Pain	Y	N	
Glare/Light Sensitivity	Y	N		Osteoporosis	Y	N	
Dryness	Y	N		**Neurological** *(nervous system)*			
Itching/Burning	Y	N		Weakness	Y	N	
Other Eye Problems	Y	N		Tingling	Y	N	
Ear, Nose, Mouth, and Throat				**Falls**	Y	N	
Sinus Congestion	Y	N		**Endocrine** *(internal/glands)*			
Chronic Cough	Y	N		Thyroid, Diabetes	Y	N	
Dry Mouth/Throat	Y	N		Hormone Rep	Y	N	
Cardiovascular *(heart/vessels)*				**Allergies/Immunologic**			
Pacemaker	Y	N		Seasonal Allergies	Y	N	
Respiratory *(lungs/breathing)*				Hay Fever	Y	N	
Chronic Bronchitis	Y	N		**Psychiatric**	Y	N	
Asthma	Y	N		**Anxiety**	Y	N	
Gastrointestinal *(stomach/intestines)*				**Depression**	Y	N	
Stomach/Intestines	Y	N		**Tuberculosis**	Y	N	
Are you pregnant?	Y	N	Due Date				
Smoke/Chew Tobacco	Y	N	Packs per Day/How long?				
Alcohol Consumption	Y	N					
Have you declared an advanced directive of DNR? *(Do Not Resuscitate)*					Y	N	

Please list any surgeries or other conditions, which you've been treated/hospitalized for:

Date	Surgery/Hospitalization	Reason

Check any **OVER-THE-COUNTER** medications you have taken within the last month?

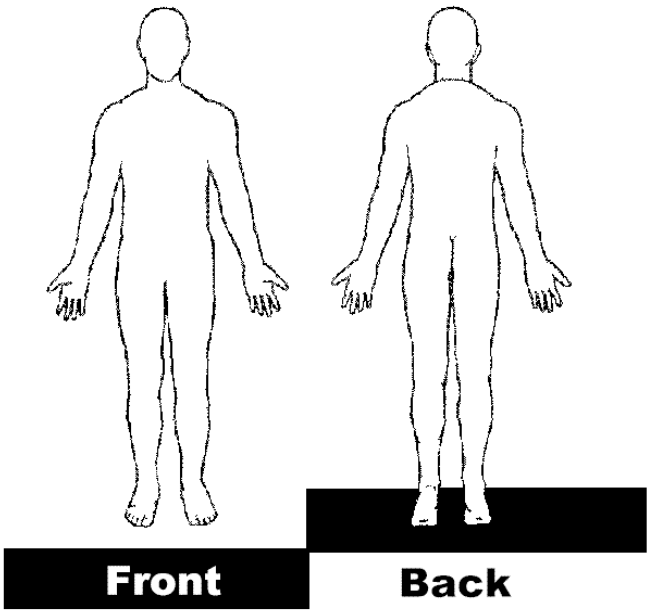
☐ Aspirin ☐ Tylenol ☐ Advil/Motrin ☐ Ibuprofen
☐ Laxatives ☐ Decongestants ☐ Antihistamines ☐ Antacid
☐ Vitamins/Mineral Supplements ☐ Glucosamine/Chondroitin

Please list the **PRESCRIPTION** medications you are currently taking and the dosage if known:

Medication	Dosage	Medication	Dosage
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	
Have you taken ANY prescription antibiotics (ex. Cipro) in the last 6 months? **Y N**		Name of Antibiotic:	

During the past month, have you been feeling down, depressed or hopeless? **Yes** **No**

During the past month, have you had little interest or pleasure in activities you normally enjoy? **Yes** **No**



Please mark the diagram with your symptoms in the appropriate location:

Pain

Numbness

Tingling, Asleep, Abnormal

Please rate your pain level on a scale of 0-10 *(0 being NO pain and 10 being worst)*:

_____ /10

Please list any additional information that would assist us with your care: _____

_____

_____

_____

_____

Patient Signature: _____ Date: _____