PECONIC PHYSICAL THERAPY MEDICAL QUESTIONAIRE

NAME: _____ OCCUPATION: _____

LEISURE ACTIVITIES: _____

LIST MEDICATIONS YOU ARE ALLERGIC TO: _____

ARE YOU LATEX SENSITIVE? YES NO

DO YOU HAVE AN ADVANCED DIRECTIVE OF DO NOT RESUCITATE? YES NO

PLEASE CHECK ANY OF THE FOLLOWING WHOSE CARE YOU ARE UNDER

___ MD ___ PSYCHIATRIST/PSYCHOLOGIST ___OTHER
___ OSTEOPATH ___ PHYSICAL THERAPIST _____
___ DENTIST ___ CHIROPRACTOR

DO YOU HAVE A DEFIBRILLATOR OR PACEMAKER? YES NO. IF YES, CIRCLE WHICH ONE.

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

YES NO	CANCER.	YES NO	RHEUMATOID ARTHRITIS
YES NO	HEART PROBLEMS	YES NO	OSTEOARTHRITIS
YES NO	HIGH BLOOD PRESSURE	YES NO	DEPRESSION
YES NO	CIRCULATION PROBLEMS	YES NO	HEPATITIS
YES NO	ASTHMA	YES NO	TUBERCULOSIS
YES NO	EMPHYSEMA/BRONCHITIS	YES NO	STROKE
YES NO	CHEMICAL DEPENDENCY	YES NO	KIDNEY DISEASE
YES NO	THRYROID PROBLEMS	YES NO	ANEMIA
YES NO	MULTIPLE SCLEROSIS	YES NO	EPILEPSY/SEIZURES
YES NO	FIBROMYALGIA	YES NO	LYMES

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS YOU HAVE BEEN HOSPITALIZED, INCLUDING THE APPROXIMATE DATE:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

PLEASE LIST ANY MEDICATION YOU ARE CURRENTLY TAKING, PRESCRIPTION AND OVER THE COUNTER

1. _____ 2. _____ 3. _____

4 _____ 5. _____ 6. _____

HAVE YOU RECENTLY NOTED:

YES NO WEIGHT LOSS/GAIN	YES NO WEAKNESS
YES NO NAUSEA/ VOMITING	YES NO FEVER/CHILLS/SWEATS
YES NO FATIGUE	YES NO NUMBNESS OR TINGLING
YES NO LOSS OF BOWEL OR BLADDER	YES NO DROP ATTACKS