Layton Physical Therapy Co., Inc.
Past Medical History Questionnaire

Patient Name:_____ **Date:**_____

Do you now or have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Anemia			Dizziness/Fainting			Parkinson's		
Anxiety			Fibromyalgia			Pneumonia		
Arthritis/Osteo/Rheumatoid			Headaches			Seizures/Epilepsy		
Asthma/Breathing Difficulties			Head Injury/Concussion			Shoulder Problems		
Back Problems			Heart Attack			Shortness of Breath		
Balance Disorders			Heart Disease			Skin Disorder		
Cancer			Hernia			Spinal Cord Injury		
Cerebral Palsy			Hepatitis			Spinal Stenosis		
Chest Pain/Angina			High/Low Blood Pressure			Stroke/TIA		
COPD			Multiple Sclerosis			Thyroid Problems		
Deep Vein Thrombosis			Muscular Dystrophy			Tuberculosis		
Depression			Neck Problems			Tumor		
Diabetes Controlled			Neuropathy			Vascular Disease		
Diabetes Uncontrolled			Osteoporosis			Wounds		
If you answered "yes" to any of the above, please explain and give approximate date(s):								

Please indicate Yes or No if you are or ever had:

	Yes	No		Yes	No		Yes	No
Abnormal Posture			Hearing Loss			Radiating Pain		
Changes in Bowel or Bladder			Hypersensitivity to Heat/Cold			Recent Weight Loss or Gain		
Cortisone Injections			Metal Implants			Surgeries - Orthopedic		
Difficulty Sleeping			Pacemaker			Surgeries - Other		
Difficulty Walking			Post Mastectomy Lymphedema			Vision Problems		
Fractures			Pregnant/Abnormal Periods			Other:		
If you answered "yes" to any of the above, please explain and give approximate date(s):								
Do you have any allergies:	No	Yes, list allergies:						
Are you presently taking any medications, including over the counter, prescriptions, vitamins/herbs/minerals?							No	Yes
If yes, list dosage and frequency:								