



ATLAS

Physical Therapy & Sports Medicine

HEALTH HISTORY QUESTIONNAIRE

Name _____ ACCOUNT #: _____ DATE: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO	DON'T KNOW	
_____	_____	_____	AIDS/HIV
_____	_____	_____	Arthritis, Joints Affected: _____
_____	_____	_____	Asthma
_____	_____	_____	Back problems
_____	_____	_____	Broken bones
_____	_____	_____	Cancer, what type: _____
_____	_____	_____	COPD or emphysema
_____	_____	_____	Diabetes
_____	_____	_____	Dizziness
_____	_____	_____	Eating disorders
_____	_____	_____	Epilepsy or seizure disorder
_____	_____	_____	Head injuries; Accident, headaches, fainting
_____	_____	_____	Heart problems
_____	_____	_____	Hepatitis, A, B, or C
_____	_____	_____	High blood pressure
_____	_____	_____	History of falls
_____	_____	_____	Orthopedic problem, explain _____
_____	_____	_____	Pneumonia
_____	_____	_____	Smoking
_____	_____	_____	Stomach problems
_____	_____	_____	Stroke
_____	_____	_____	Tuberculosis
_____	_____	_____	Any surgical procedures in the past 10 years? If yes, list _____

PLEASE EXPLAIN ANY OTHER MEDICAL ISSUES YOU FEEL WE SHOULD KNOW ABOUT:

PRESCRIPTION MEDICATIONS: _____

PRESCRIPTION ALLERGIES: _____

ENVIRONMENTAL ALLERGIES: _____

TAPE/ADHESIVE ALLERGIES: _____