Yorick Wijting, PT, DPT
Licensed Physical Therapist

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PATIENT MEDICAL QUESTIONNAIRE

Mark if you have/have had any of the following. Provide detail in right column, including medication.

Unexpected weight loss	Yes / No	Specify
Weakness/Cramps	Yes / No	Specify
Numbness/Tingling	Yes / No	Specify
Nausea/Vomiting	Yes / No	Specify
Fever/Chills/Sweats	Yes / No	Frequency, Duration
High blood pressure	Yes / No	Medication
Heart problems	Yes / No	Specify, Medication
Circulation problems	Yes / No	Specify, Medication
Loss of consciousness	Yes / No	Specify, Medication
Sensitivity to heat/ice	Yes / No	Specify
Balance problems	Yes / No	Medication, Treatment
Dizzyness	Yes / No	Specify
Falls	Yes / No	How many in past year
Kidney problems	Yes / No	Medication
Nervous disorders	Yes / No	Specify
Hearing problems	Yes / No	Specify
Vision problems	Yes / No	Specify
Breathing problems	Yes / No	Specify
Voice/Swallowing issues	Yes / No	Specify
Stroke/Seizures	Yes / No	Frequency, Medication
Diabetes	Yes / No	Type, Management
Headaches	Yes / No	Frequency, Severity, Medication
Implanted device/metal	Yes / No	Specify
Current pregnancy	Yes / No	Expected delivery date
Arthritis	Yes / No	Medication
Osteoporosis/Osteopenia	Yes / No	Medication
Cancer	Yes / No	Specify
Radiation/Chemotherapy	Yes / No	Specify
Allergies	Yes / No	Specify
Height/weight	Height:	Weight:

Other relevant information: _____

_____

What do you hope to gain from physical therapy? _____

_____

Patient/Personal Representative signature: _____ Date: _____