PORTSMOUTH
1 Cate Street | Portsmouth, NH 03801
P: 603-431-0277 | **F:** 603-422-8849

DOVER
60 Pointe Place, Suite 1 | Dover, NH 03820
P: 603-740-1300 | **F:** 603-740-0060

MEDICAL HISTORY QUESTIONNAIRE

Name ______________________________ Today's Date: ______________________________

Date of Birth: ______________________________ Height: ______________ Weight: ______________

Primary Care Doctor: ______________________________ Doctor's Phone#: ______________________________

Have you ever been told by a doctor that you have or had any of the following:

- ☐ Acid Reflux/Heartburn
- ☐ Alcohol/Drug Dependence
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer/Tumor (Explain) ______________________________

____
- ☐ Chest Pain/Chest Discomfort
- ☐ Diabetes
- ☐ Edema/Swollen Joints
- ☐ Epilepsy/Seizure Disorder
- ☐ Head Injury/Concussion
- ☐ Heart Condition*
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Neck Injury
- ☐ Osteoporosis
- ☐ Phlebitis/Embolism
- ☐ Respiratory Condition**
- ☐ Stroke (Date) ______________________
- ☐ Tobacco Use – Type ______________________

  Frequency ______________________

*Irregular heartbeats/Heart Valve Problem/Murmurs/Coronary/Rheumatic/Congenital Heart Disease
**Shortness of Breath/Asthma/Emphysema/COPD/Lung Disease/Chronic Cough

List below any allergies to food or medications:

____

____

Do you currently experience any of the following?

- ☐ Back or Neck Pain
- ☐ Joint/Tendon/Muscular Pain
- ☐ Difficulty Sleeping
- ☐ Frequent/Severe Headaches
- ☐ Frequent Ankle Pain
- ☐ Anxiety/Depression
- ☐ Fatigue/Lack of Energy
- ☐ Edema/Swollen Joints
- ☐ Ringing in Ears

Do you wear glasses or contacts? ☐ Yes ☐ No

Have you had Lasik Surgery? ☐ Yes ☐ No

Plastic Surgery? ☐ Yes ☐ No

Have you had any Fractures/Broken Bones/Dislocations? ☐ Yes ☐ No
If yes, list them below:

____

____

(OVER)

List any hospitalizations, surgical procedures or significant illnesses you have had within the last five years:

____

____

Do you currently have any medical condition for which a physician has recommended any restrictions or physical therapy? *If yes please explain:*

____

____

Is there any additional information about your previous medical history or current medical status that is important for our staff to know in designing a personalized exercise/wellness program?

____

____

Please indicate the date of your most recent physical examination and the results:

____

____

How did you hear about us? ______________________________ Relationship? ____________________

______________________________ ____________________
Patient's Signature – Parent/Guardian if under 18 Date

______________________________ ____________________
Reviewing Therapist's Signature Date