Marcotte Physical Therapy, Inc.

Medical Health Questionnaire

Pulmonary Problems (if yes, check boxes)

□ COPD/Emphysema
□ Asthma
□ Tuberculosis
□ Pneumonia
□ CPAP/BiPAP machine
□ Other: _____
□ Pulmonary Embolism
□ Use of O_2 _____ L
□ Sleep Apnea
□ Shortness of Breath at Rest/Exertion
□ Tracheotomy

Cardiac Problems (if yes, check boxes)

□ Congestive Heart Failure
□ High Blood Pressure
□ High Cholesterol
□ Angina/Chest Pain
□ Coronary Heart Disease
□ Endocarditis
□ Rheumatic Fever
□ DVT (Deep Vein Thrombosis)
□ Pacemaker, when? _____
□ Defibrillator, when? _____
□ Cardiac Catherization
□ Heart Valve Problems
□Heart Murmur
□ Heart Attack
□ Peripheral Vascular Disease
□ Cardiomyopathy
□ Irregular Heart Beat
□ Family History of Heart Disease

Normal Blood Pressure (if Known) /

Eye, Ear, Nose, Throat Problems (if yes, check boxes)

□ Cataracts
□ Photophobia
□ Macular Degeneration
□ Legally Blind
□ Enucleation □ L □ R
□ Glaucoma □ L □ R
□ Hearing Loss □ L □ R
□ Sign Language
□ Vocal Cord Polyps/Nodules
□ Peripheral Vision Problems
□ Glasses
□ Contact Lenses
□ Prosthesis (electrolarynx)
□ Tinitus
□ Vestibular
□ Hearing Aids □ L □ R
□ Dentures

Other: _____

Genitourinary Problems (if yes, check boxes)

□ Kidney Stones
□ Urinary Tract Infections
□ Urinary Incontinence
□ Pelvic Floor Dysfunction
□ Are you Pregnant?
□ Other: _____
□ Prostrate Problems
□ Dialysis: # of Days _____
□ Peritoneal
□ Hemodialysis
□ Yes □ No

Gastrointestinal problems (if yes, check boxes)

□ Hepatitis: Type
□ Liver Disease
□ Peptic Ulcer
□ Irritable Bowel / Crohn's
□ Other: _____
□ GERD/Acid reflux
□ Hiatal Hernia
□ Pancreatitis
□ Gall Bladder

Autoimmune Disease (if yes, check boxes)

□ Lupus
□ Other: _____
□ Sjogrens

Neurological Problems (if yes, check boxes)

□ CVA/Stroke
□ Transient Ischemic (TIA)
□ Dementia/Alzheimer's
□ Parkinson's
□ Multiple Sclerosis
□ Peripheral Neuropathy
□ Muscular Dystrophy
□ Other: _____
□ Seizures/Epilepsy
□ Head Trauma
□ Dizziness/Vertigo
□ Fainting
□ Headaches
□ ALS
□ Cerebral Palsy

Musculoskeletal Problems (if yes, check boxes)

□ Fracture
□ Arthritis
□ Disc Disease
□ Osteoporosis
□ Gout
□ Lyme disease
□ Other: _____
□ Fibromyalgia
□ Back/Neck Pain
□ Unsteady Gait
□ Limited movement
□ Joint Pain
□ Tick Borne Disease

Skin (if yes, check boxes)

□ Rash
□ Open Wounds
□ Psoriasis
□ Shingles
□ Head Lice
□ Other: _____
□ Edema
□ Cellulitis
□ Pigmentation disorder
□ Ring Worm
□ Scabies

Cancer History (if yes, check boxes)

□ Cancer Type
□ Radiation
□ Family History
□ Chemotherapy

Hematologic Problems (if yes, check boxes)

□ Anemia
□ Clotting Problems
□ Neutropenia Precautions
□ Other: _____
□ HIV
□ AIDS

Endocrine Problems (if yes, check boxes)

□ Hypothyroidism
□ Diabetes: Type:
□ Hyperthyroidsim
□ Insulin □ Non-Insulin

Pyschosocial History (if yes, check boxes)

□ Smoking/Tobacco
□ Panic/Anxiety Attacks
□ Suicidal Tendencies
□ Alcohol Use: _____Drinks per day/week
□ Substance Use: _____
□ Depression
□ Bipolar Disorder

Do you feel your substance / alcohol use is a problem?
□ Y □ N
□ Other: _____

I have completed the Marcotte Physical Therapy Medical History Questionnaire to the best of my knowledge and the information has been reviewed with me by my therapist.

Signature: _____ Relationship to Patient: □ Self □ Other: _____

Therapist Signature: _____ Date: _____Time: _____