Petaluma Orthopaedic and Sports Therapy
POST
WELLNESS BY DESIGN

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22 MEDICAL/SURGICAL HISTORY

a Please check if you have ever had:

(1) ☐ Arthritis
(2) ☐ Broken bones/ fractures
(3) ☐ Osteoporosis
(4) ☐ Blood disorders
(5) ☐ Circulation/vascular problems
(6) ☐ Heart problems
(7) ☐ High blood pressure
(8) ☐ Lung problems
(9) ☐ Stroke
(10) ☐ Diabetes/ high blood sugar
(11) ☐ Low blood sugar/ hypoglycemia
(12) ☐ Head injury
(13) ☐ Multiple sclerosis
(14) ☐ Muscular dystrophy
(15) ☐ Parkinson disease
(16) ☐ Seizures/epilepsy
(17) ☐ Allergies
(18) ☐ Developmental or growth problems
(19) ☐ Thyroid problems
(20) ☐ Cancer
(21) ☐ Infectious disease (eg, tuberculosis, hepatitis)
(22) ☐ Kidney problems
(23) ☐ Repeated infections
(24) ☐ Ulcers/stomach problems
(25) ☐ Skin diseases
(26) ☐ Depression
(27) ☐ Other:_____

b Within the past year, have you had any of the following symptoms? (Check all that apply)

(1) ☐ Chest pain
(2) ☐ Heart palpitations
(3) ☐ Cough
(4) ☐ Hoarseness
(5) ☐ Shortness of breath
(6) ☐ Dizziness or blackouts
(7) ☐ Coordination problems
(8) ☐ Weakness in arms or legs
(9) ☐ Loss of balance
(10) ☐ Difficulty walking
(11) ☐ Joint pain or swelling
(12) ☐ Pain at night
(13) ☐ Difficulty sleeping
(14) ☐ Loss of appetite
(15) ☐ Nausea/vomiting
(16) ☐ Difficulty swallowing
(17) ☐ Bowel problems
(18) ☐ Weight loss/gain
(19) ☐ Urinary problems
(20) ☐ Fever/chills/sweats
(21) ☐ Headaches
(22) ☐ Hearing problems
(23) ☐ Vision problems
(24) ☐ Other:_____

c Have you ever had surgery? (1) ☐ Yes (2) ☐ No
If yes, please describe, and include dates:

	Month	Year
_____	☐☐	☐☐☐☐
_____	☐☐	☐☐☐☐
_____	☐☐	☐☐☐☐

For men only: d Have you been diagnosed with prostate disease?
(1) ☐ Yes (2) ☐ No

For women only:
Have you been diagnosed with:
e Pelvic inflammatory disease?
(1) ☐ Yes (2) ☐ No
f Endometriosis?
(1) ☐ Yes (2) ☐ No
g Trouble with your period?
(1) ☐ Yes (2) ☐ No
h Complicated pregnancies or deliveries?
(1) ☐ Yes (2) ☐ No
i Pregnant, or think you might be pregnant?
(1) ☐ Yes (2) ☐ No
j Other gynecological or obstetrical difficulties?
(1) ☐ Yes (2) ☐ No
If yes, please desribe:_____

23 CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

a Describe the problem(s) for which you seek physical therapy:
_____
_____

b When did the problem(s) begin (date)? Month ☐☐ Year ☐☐☐☐
c What happened? _____
_____

d Have you ever had the problem(s) before?
(1) ☐ Yes
(a) What did you do for the problem(s)? _____
_____
(b) Did the problem(s) get better?
1. ☐ Yes 2. ☐ No
(c) About how long did the problem(s) last?_____
(2) ☐ No

23 Current Condition(s)/Chief Complaint(s) (continued)

e How are you taking care of the problem(s) now? _____
_____

f What makes the problem(s) better? _____
_____

g What makes the problem(s) worse? _____
_____

h What are your goals for physical therapy? _____
_____

i Are you seeing anyone else for the problem(s)? (Check all that apply)

(1) ☐ Acupuncturist
(2) ☐ Cardiologist
(3) ☐ Chiropractor
(4) ☐ Dentist
(5) ☐ Family practitioner
(6) ☐ Internist
(7) ☐ Massage therapist
(8) ☐ Neurologist
(9) ☐ Obstetrician/gynecologist
(10) ☐ Occupational therapist
(11) ☐ Orthopedist
(12) ☐ Osteopath
(13) ☐ Pediatrician
(14) ☐ Podiatrist
(15) ☐ Primary care physician
(16) ☐ Rheumatologist
Other:_____

24 FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply):

a ☐ Difficulty with locomotion/movement:
(1) ☐ bed mobility
(2) ☐ transfers (such as moving from bed to chair, from bed to commode)
(3) ☐ gait (walking)
(a) ☐ on level (c) ☐ on ramps
(b) ☐ on stairs (d) ☐ on uneven terrain
b ☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)
c ☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
d ☐ Difficulty with community and work activities/integration
(1) ☐ work/school
(2) ☐ recreation or play activity

25 MEDICATIONS

a Do you take any prescription medications? (1) ☐ Yes (2) ☐ No
If yes, please list: _____
_____

b Do you take any nonprescription medications? (Check all that apply)

(1) ☐ Advil/Aleve
(2) ☐ Antacids
(3) ☐ Ibuprofen/ Naproxen
(4) ☐ Antihistamines
(5) ☐ Aspirin
(6) ☐ Decongestants
(7) ☐ Herbal supplements
(8) ☐ Tylenol
(9) ☐ Other: _____
_____
_____

c Have you taken any medications previously for the condition for which you are seeing the physical therapist?
(1) ☐ Yes (2) ☐ No If yes, please list:_____
_____

26 OTHER CLINICAL TESTS—Within the past year, have you had any of the following tests? (Check all that apply)

a ☐ Angiogram
b ☐ Arthroscopy
c ☐ Biopsy
d ☐ Blood tests
e ☐ Bone scan
f ☐ Bronchoscopy
g ☐ CT scan
h ☐ Doppler ultrasound
i ☐ Echocardiogram
j ☐ EEG (electroencephalogram)
k ☐ EKG (electrocardiogram)
l ☐ EMG (electromyogram)
m ☐ Mammogram
n ☐ MRI
o ☐ Myelogram
p ☐ NCV (nerve conduction velocity)
q ☐ Pap smear
r ☐ Pulmonary function test
s ☐ Spinal tap
t ☐ Stool tests
u ☐ Stress test (eg, treadmill, bicycle)
v ☐ Urine tests
x ☐ X-rays
y ☐ Other:_____