

SYDNEY SPORTS & ORTHOPAEDIC PHYSIOTHERAPY

MEDICAL HISTORY SCREENING QUESTIONNAIRE

Confidential

Are you currently seeing any of the following?

- Medical Doctor
- Osteopath
- Chiropractor
- Dentist
- Psychiatrist/psychologist
- Massage therapist
- Other physiotherapist

Have you ever been diagnosed with any of the following?

- Cancer
- Heart problems
- High blood pressure
- Asthma
- Emphysema
- Chemical dependency (eg. alcoholism)
- Thyroid problems
- Diabetes
- Multiple sclerosis
- Osteoarthritis
- Rheumatoid arthritis
- Other arthritis
- Depression
- Hepatitis
- Tuberculosis
- Stroke
- Kidney disease
- Anaemia
- Epilepsy
- Other _____

Are you (or do you believe you are) currently pregnant?

- YES
- NO

How many caffeinated coffee or other caffeinated drinks do you consume per day?

- 0
- 1
- 2
- 3
- 4
- 5
- >5

How many packs of cigarettes do you smoke per day?

- 0
- ½
- ½-1
- 1-1½
- 1½-2
- >2

How many days per week do you drink alcohol?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7

If one drink equals one beer or glass of wine, how many drinks would you consume at an average sitting?

- 1
- 2
- 3
- 4
- 5
- 6
- > 6

How many days per week do you use drugs such as marijuana, cocaine etc.?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7

Please list any previous injuries for which you have been treated, including the approximate date of injury:

Please list any known allergies:

Has anyone in your immediate family been treated for any of the following?

- Diabetes
- Tuberculosis
- Heart disease
- High blood pressure
- Stroke
- Kidney disease
- Cancer
- Arthritis
- Anaemia
- Headaches
- Epilepsy
- Mental illness (eg. depression)
- Chemical dependency (eg. alcoholism)

Have you experienced any of the following in the past four weeks?

- Fever/chills/sweats
- Unexplained weight change
- Excessive tiredness
- Nausea/vomiting
- Bowel dysfunction
- Numbness
- Weakness
- Dizziness/light-headedness
- Passing out
- Night pain
- Shortness of breath
- Urinary frequency changes
- Sexual dysfunction

Please list any surgery you have undergone, including the approximate date:

Which of these over the counter medications have you taken in the past week?

- Aspirin
- Antiinflammatories (eg. neurofen, ibuprofen, advil)
- Glucosamine and chondroitin
- Laxatives
- Decongestants
- Antihistamine
- Antacids
- Vitamin/mineral supplements
- Other _____

Please list prescription medications you are taking (include pills, injections, patches)
