

Medical History and Health Screening Form - Male

Directions: Please print this form and fill out the information as completely as possible. Please have the completed form available for your therapist to review with you at your appointment. The information you provide is strictly confidential and will be used to help us provide the most appropriate treatment for you. With your permission, this information may also be shared with your health care provider of choice (such as physician or nurse practitioner). Thank you for your cooperation.

Personal Information

Name:	Age:	Date of Birth:
Signature:	Today's Date:	

Medical History

1. When was your most recent physical/medical check-up?				
2. When was your most recent prostate exam?				
3. Do you exercise regularly? If yes, what type of activity and how often? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Do you smoke tobacco? If yes, how often? _____ cigarettes/day _____ packs/day for _____ years	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5. If you used to smoke, when did you quit?				
6. Please check the medical conditions below if they apply to you:				
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Chest pain/Angina <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Asthma <input type="checkbox"/> Lung disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Respiratory infection <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____ </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Vascular disease <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney disease <input type="checkbox"/> Anemia </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Kidney stones <input type="checkbox"/> Cancer <input type="checkbox"/> Neuropathy <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Pelvic organ prolapse <input type="checkbox"/> Yeast infection <input type="checkbox"/> Sexually transmitted disease (STD) </td> </tr> </table>		<input type="checkbox"/> Diabetes <input type="checkbox"/> Chest pain/Angina <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Asthma <input type="checkbox"/> Lung disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Respiratory infection <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____	<input type="checkbox"/> Vascular disease <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney disease <input type="checkbox"/> Anemia	<input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Kidney stones <input type="checkbox"/> Cancer <input type="checkbox"/> Neuropathy <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Pelvic organ prolapse <input type="checkbox"/> Yeast infection <input type="checkbox"/> Sexually transmitted disease (STD)
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Notes/Explanation for any item checked above:				

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7. Please list any surgeries you have previously had, including approximate dates:
8. Please list any relevant diagnostic tests, including approximate dates:
9. Current prescription or over-the-counter medications and dosages:

Reason for Physical Therapy

10. Primary reason for seeking physical therapy:
11. Your goals for physical therapy:

Pain Assessment

12. If you currently have pain, please rate your current pain from 1-10 (10 being the worst).	
13. Where is your pain located?	
14. How long have you had this condition?	
15. Is your condition: <input type="checkbox"/> Improving <input type="checkbox"/> Getting worse <input type="checkbox"/> No different <input type="checkbox"/> Variable	
16. Do you have any limitations because of your pain? If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Thank you for your time in completing this information.