Complete **REHAB & SPORT**
A Division of CRS Homebased Physical Therapy, P.C.
672 South Country Road East Patchogue, NY 11772
631.654.5282 fax 631.654.5253

Medical History Questionnaire

Please fill out this form to the best of your knowledge. Your therapist will review it with you during your initial evaluation.

Name_____ **Date**_____
Age____ **Sex**____ **Height**_____ **Weight**_____ **Occupation**_____

Address_____
Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Primary Physician_____ **Phone**_____
Emergency Contact_____ **Phone**_____

Have you ever/do you presently have any of the following (PLEASE CHECK):

( ) abnormal EKG	( ) arthritis	( ) asthma	( ) hernia	( ) chest pain
( ) diabetes	( ) dietary restriction		( ) epilepsy	( ) fainting
( ) headaches	( ) heart attack		( ) heart murmur	
( ) cardiovascular problems		( ) hypertension		( ) back injury
( ) orthopedic problems		( ) recent surgery		( ) short of breath
( ) any known allergies		( ) other		

If you checked any of the above, or if you have any other medical conditions, please list and explain:

_____
_____
_____
_____

Are you currently taking any medications? If yes, please list here:

_____
_____
_____
_____

In the past 12 months have you had any of the following?

Physical Exam	**YES**	**NO**
EKG	**YES**	**NO**
Blood Pressure Checked	**YES**	**NO**
Blood Work	**YES**	**NO**
Stress Test	**YES**	**NO**