



Davis & DeRosa Physical Therapy, Inc.

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## Health Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Medical Illnesses	Yes	No	Explain all "Yes" answers
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers/Gastritis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Drug Allergies/Sensitivities:

\_\_\_\_\_

Previous Surgeries:

\_\_\_\_\_

Current Medications:

\_\_\_\_\_

Social History:

Do you currently smoke cigarettes or cigars? Yes  No

Have you smoked in the past? Yes  No

How many years have you/did you smoke? \_\_\_\_\_

Do you drink alcohol? Yes  No

If Yes, how much per week?

\_\_\_\_\_

Sports and Leisure Activities:

\_\_\_\_\_

\_\_\_\_\_