Medicare Packet

PATIENT HEALTH HISTORY & QUESTIONNAIRE

Patient Name:
Occupation: _____ Sex: ☐ Male ☐ Female ☐ Gender Diverse Height: _____ Weight: _____

Please list current medications (Including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Medication	Dosage	Freq	Please indicate route by checking box:
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐

If you are currently not taking any medications, please indicate NO by checking the box: ☐

Surgery / Hospitalization, please include date and reason.
Date: _____ Reason: _____

Please list any known allergies (including medications, latex, etc.) _____

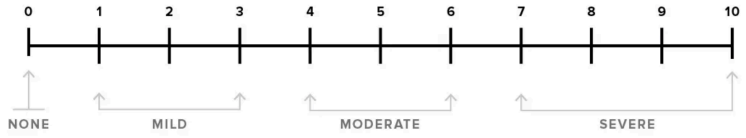
Any **significant** weight gain or loss in the last year? ☐ Yes ☐ No (+/-) _____ lbs

Are you currently experiencing any of the following?			
Nausea or vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/chronic cough	☐ Yes ☐ No	Pain wakes me at night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent fever, chills, sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No

Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No
Hearing loss/ringing in ears	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual weakness	☐ Yes ☐ No	Fatigue or myalgia	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Falls	☐ Yes ☐ No

Please indicate the body part(s) in which you are experiencing pain: _____

I would rate my current pain (please indicate appropriate number): _____



I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature:_____ Date: _____

Patient Name/Responsible Party: _____ Guardian (if applicable): _____