KIMA | CENTER FOR PHYSIOTHERAPY & WELLNESS

General Medical History

Do the current symptoms interrupt your sleep? ☐ Yes ☐ No

Do your symptoms change with coughing or sneezing? ☐ Yes ☐ No

Have you had any recent changes in bowel or bladder function? ☐ Yes ☐ No

Do you experience any dizziness or vertigo? ☐ Yes ☐ No

Have you had any recent change in your weight or appetite? ☐ Yes ☐ No

Do you have any intolerance to hot or cold? ☐ Yes ☐ No

How many ounces of water do you drink a day?_____

How many hours of sleep do you get per night?_____

Do you have any bruising or bleeding disorders? ☐ Yes ☐ No

Have you had any skin changes such as rashes or discoloration? ☐ Yes ☐ No

Have you experienced any recent vision change (blurred, double vision)? ☐ Yes ☐ No

Have you had a recent episode of nausea or vomiting? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have osteoporosis? ☐ Yes ☐ No

What was the date of your last bone scan?_____

Do you have any allergies or asthma? ☐ Yes ☐ No

If yes please specify:_____

Do you have any cardiac problems? ☐ Yes ☐ No

Have you noticed any shortness of breath or decrease in exercise tolerance? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do you have a history of cancer? ☐ Yes ☐ No

Do you have a history of neck or back problems? ☐ Yes ☐ No

Are there any other conditions or illnesses that we should be aware of? ☐ Yes ☐ No

If so, please specify: _____

List any past surgeries that you have had:_____

List any history of falls or traumas: _____