



Andover Physical Therapy
 13831 Round Lake Blvd.
 Andover, MN 55030
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Health History Questionnaire

Name: _____ DOB: ____/____/____ Date: ____/____/____

Have you or a family member ever had...	You	Family		You	Famil
Angina/Chest pain	Y/N	Y/N	Osteoarthritis	Y/N	Y/N
Broken Bones	Y/N	Y/N	Osteoporosis or Osteopenia	Y/N	Y/N
Cancer	Y/N	Y/N	Rheumatoid Arthritis	Y/N	Y/N
Diabetes	Y/N	Y/N	Stroke	Y/N	Y/N
Heart disease/Heart attack	Y/N	Y/N	Multiple Sclerosis	Y/N	Y/N
High blood pressure	Y/N	Y/N	Other	Y/N	Y/N
Do you have history of?	Yes	No	Do you have history of?	Yes	No
Allergies/ Asthma			Depression		
Are you pregnant			Bronchitis		
Dizziness/Balance problems			Headaches		
Hernia			Kidney disease or problems		
Metal implants			Nervous disorders		
Rheumatic fever			Pacemaker		
Seizures			Sensitive to heat/ice		
STD's			Ulcers		
In the past few months have you had...	Yes	No	Have you had...	Yes	No
A change in your health			Changes in appetite		
Changes in bowel or bladder functions			Difficulty swallowing		
Dizziness			Fever/Chills/Sweats		
Nausea/Vomiting			Numbness or tingling		
Shortness of breath			Unexplained weight changes		
Upper respiratory infection			Urinary tract infection		
Are you under stress?	Yes	No			
Are your symptoms getting	Worse	Same	Better		
Describe your level of activity	Not Active	Active	Very Active		
Do you have a problem with	Vision	Speech	Hearing		
Do you smoke	No	Yes	___Packs/ day		
How are your able to sleep?	Poor	Fair	Medicated		
How do you most effectively learn?	Audio	Visual	Hands-on		
How often do you drink alcohol?	Never	Once/week	___Times/week		

I have completed the above information to the best of my ability.

Patient Signature: _____ Date: _____