BETTERLIFE PHYSIO
physio in your home

Patient Medical Questionnaire

Name:_____ Date: ____/____/____

A thorough knowledge of your past medical history allows us to provide the correct treatment safely. Please indicate with a tick if you **currently have** or **have had in the past** or **take medication** to control any of the following medical conditions:

	Y	N
High blood pressure	☐	☐
Heart problems e.g. • Chest pain • Heart attack • Raised cholesterol • Cardiac stenting • Heart surgery • Pacemaker or other implanted device	☐	☐
Lung Problems e.g • asthma • bronchiectasis • COPD/COAD	☐	☐
Stroke	☐	☐
Diabetes – Type 1	☐	☐
Diabetes – Type 2	☐	☐
Epilepsy	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐

	Y	N
Any major operations: Please describe:	☐	☐
Broken bones	☐	☐
Kidney problems	☐	☐
Falls	☐	☐
Dementia / Alzheimers	☐	☐
Have you been in hospital in the last 12 months? How many times? What for?	☐ If yes... time(s) For:	☐ ☐
Any other significant medical problem not listed here (injuries / illnesses / surgery)	☐	☐

Are you currently taking any prescribed medications? (*please list*)

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