POW PHYSICAL THERAPY
Pilates, **O**rthopedics, **W**omen's Health

Patient Name:______________________________

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Patient Health Questionnaire and History

1. Have you ever had? (If yes, please explain)
   High blood pressure Y/ N____
   Heart or Circulation Disorders Y/ N____
   Seizures Y/ N____
   Dizzy Spells Y/ N____
   Diabetes Y/ N____
   Cancer Y/ N____
   Arthritis Y/ N____
   Immune Deficiency Disease Y/N____
   Leakage of bladder or bowel Y/ N____
   Frequent Urination Y/ N____
   Painful Intercourse Y/ N____
   Depression Y/ N____
   Headaches Y/ N____
   Other Y/ N____
2. Please list any surgeries you have had along with procedure and dates, if possible.
   ____
3. Do you have any METAL anywhere in your body (pins/ plates/ pacemaker) other than teeth?
   Y/ N Describe:____
4. For women only: Are you now pregnant? Y/ N If yes, how many weeks pregnant?____________
   Are you post menopausal? Y/ N If yes, date of last period?______________________________
5. Do you have any abnormal trouble with vision? Y/ N Hearing? Y/ N
6. List all allergies you may have:____
7. Have you ever taken steroids or anti coagulants for an extended period of time? Y/ N
8. Have you had any unusual weight gain or loss? Y/ N
9. List all medications you are now taking:____
   ____