PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

MEDICAL SCREENING FORM

Pelvic or Hip Pain

REASON FOR VISIT

Nature of your illness/injury:_____

Date of Onset/Surgical Date:_____

MAJOR ILLNESS/SURGICAL HISTORY

Date:_____	Type:_____
Date:_____	Type:_____
Date:_____	Type:_____

MEDICAL HISTORY

Do you have, or have you had any of the following:

☐ Yes ☐ No Heart Problems
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Mental Health Condition
☐ Yes ☐ No Women: Are you pregnant or think you may become pregnant?
☐ Yes ☐ No Depression
☐ Yes ☐ No Epilepsy/Seizures
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Polio
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Allergies
☐ Yes ☐ No Other

Details/Other:_____

_____

SPECIAL SCREENING QUESTIONS FOR PELVIC AND HIP PAIN

☐ Yes ☐ No Do you have a history of cancer?
☐ Yes ☐ No Have you recently had a major trauma, such as a fall?
☐ Yes ☐ No Have you ever had a medical practitioner tell you that you have osteoporosis?
☐ Yes ☐ No Have you ever had a physician tell you that you have a blood circulation problems in your hips?
☐ Yes ☐ No Are you currently taking steroids or have you been on prolonged steroid therapy?
☐ Yes ☐ No Does your pain ease when you rest in a comfortable position?
☐ Yes ☐ No Has a member of your immediate family (parent/sibling) ever been diagnosed with cancer?
☐ Yes ☐ No Have you recently lost weight without attempting to eat less or exercise more?
☐ Yes ☐ No Have you had a recent change in your bowel function (i.e., Black stools/Rectal bleeding)?
☐ Yes ☐ No Have you had diarrhea or constipation that has lasted for more than a few days?
☐ Yes ☐ No Do you have groin or thigh pain that increases when you cough or sneeze?
☐ Yes ☐ No Do you feel sick to your stomach to the point where you feel like vomiting?
☐ Yes ☐ No If female, have you recently experienced increased pain during your menstrual period?

CURRENT MEDICATIONS

Please list:_____

_____

PLEASE PRINT YOUR NAME BELOW

Printed Name:_____Date:_____