



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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No Depression        | <input type="checkbox"/> Yes <input type="checkbox"/> No Polio     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis      | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health Condition                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis         | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Women: Are you pregnant or think you may become pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_