

Name _____
Date: _____

PRS PAST MEDICAL HISTORY QUESTIONNAIRE

| <u>Date</u> | <u>Procedure/Surgery</u> | <u>Residual Problems / Restrictions</u> |
|-------------|--------------------------|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Comments: _____

| <u>Illness</u> | <u>Comments</u> | <u>Illness</u> | <u>Comments</u> |
|---------------------|-----------------|------------------|-----------------|
| Diabetes | _____ | Cancer (where) | _____ |
| Heart Disease | _____ | Anxiety | _____ |
| | | Depression | _____ |
| High Blood Pressure | _____ | Kidney Disease | _____ |
| Arthritis (where) | _____ | Lung Disease | _____ |
| Bowel Disease | _____ | Pacemaker | _____ |
| Multiple Myeloma | _____ | Psoriasis | _____ |
| Polio | _____ | Seizure | _____ |
| Rheumatism | _____ | Stroke | _____ |
| PTSD | _____ | Ulcers/Stomach | _____ |
| Thyroid | _____ | GERD | _____ |
| Hip Replacement | _____ | High Cholesterol | _____ |
| Knee Replacement | _____ | Skin Cancer | _____ |
| Shoulder | _____ | Memory Issues | _____ |
| | | Learning Issues | _____ |

Other: _____
Other: _____

ACTIVITIES OF DAILY LIVING

Arises ____ A.M. Retires ____ P.M. Average Hours of Sleep/24 hours ____

Sleep Difficulties: _____