
Name

Date

MEDICAL QUESTIONNAIRE

Present Physical/Mental Health Treatments

Doctors/Treatments

(Please indicate under date the last office visit (LOV) and the next office visit (NOV))

Doctor	Treatment	Dates
		(LOV) (NOV)
		(LOV) (NOV)
		(LOV) (NOV)
		(LOV) (NOV)
		(LOV) (NOV)
		(LOV) (NOV)

Special techniques to relieve problems – (hot baths, PT, OT, exercise, traction):

Present Medication/Dosage & reason for medication: (for all medications)

Medication (RX)	Dosage	Frequency	Reason for taking	

Please indicate the doctor or doctors who prescribe your medications and specific meds.

What is your major medical problems or the problem currently causing you the most problems? _____

Comments: _____

Physical Limitations- Subjective

Activity	None	Yes	Extent
Lifting			
Talking			
Hearing			
Sitting			
Climbing			
Balancing			
Stooping			
Breathing			
Driving			
Feeling			
Reaching			
Fingering			
Seeing			
Standing			
Walking			
Bending			
Kneeling			
Sleeping			