The PHYSIO THERAPY Centre

Version (Print): 08.2023

Medical History

Full Name: ____________________________________

Current Symptoms & Condition:

____

____

Do you suffer or have suffered from any of the following conditions, if yes since when?

- Thyroid? Yes [ ] / No [ ] If yes, since: __________
- Heart Disease? Yes [ ] / No [ ] If yes, since: __________
- Epilepsy? Yes [ ] / No [ ] If yes, since: __________
- Asthma? Yes [ ] / No [ ] If yes, since: __________
- Diabetes? Yes [ ] / No [ ] If yes, since: __________
- Cancer? Yes [ ] / No [ ] If yes, since: __________
- High Blood Pressure? Yes [ ] / No [ ] If yes, since: __________
- High Cholesterol? Yes [ ] / No [ ] If yes, since: __________
- Do you have any Allergies? Yes [ ] / No [ ] If yes, since: __________

Please list any other serious illness, operations, or accidents you had in the past (give dates if possible).

____

____

Please list any medication you are currently taking:

____

____

Form continued over the page ...

MEN'S HEALTH: Do you suffer with any of the following symptoms/conditions?

- Erectile Dysfunction [ ]
- Peyronnie's Disease [ ]
- Chronic Pelvic Pain Syndrome [ ]

WOMEN'S HEALTH: Do you suffer with any of the following symptoms/conditions?

- Urinary Incontinence [ ]
- Overactive Bladder [ ]
- Pelvic Floor Dysfunction [ ]
- Chronic Pelvic Pain [ ]
- Pre/Post Natal [ ]

VESTIBULAR: Do you suffer with any of the following symptoms/conditions?

- Dizziness [ ]

Do you have any Allergies? Yes [ ] / No [ ] If yes, since: ________

Date Completed: ___________________________________

The details within this form are for the sole use of The Physiotherapy Centre (Waterlooville) Ltd, and will not be shared with third parties, unless legally required or at the request of the client.