

PATIENT MEDICAL HISTORY – PHYSICAL THERAPY

Date: _____ Date of birth/Age: _____
Name: _____
Contact number during the day: _____
Referring Physician: _____ Primary Care Provider: _____
Date of injury: _____ Last day of work due to injury: _____
Occupation: _____ Are you right or left handed? (circle one)
Please list any prescriptions or over-the-counter medications you are taking: _____

Are you allergic to any medications? Yes/No Please list: _____
Do you have a latex allergy? Yes/No _____
Please list any physicians you have seen or treatments you have had for this injury: _____

Have you had any diagnostic imaging for this injury? Yes/No If yes, please list type, date performed, and facility where performed: _____

Have you had surgery for this injury? Yes/No If yes, please describe, give date and surgeon: _____

Have you had any other surgeries? Yes/No If yes, please describe: _____

Do you now have or have you ever had any of the following:

Asthma/Bronchitis	Yes/No	Headaches: tension/migraine	Yes/No
Emphysema	Yes/No	Vision/hearing problems	Yes/No
Shortness of breath	Yes/No	Dizziness/fainting	Yes/No
Chest pain	Yes/No	Bowel/bladder problems	Yes/No
Congestive heart disease	Yes/No	Weakness	Yes/No
High blood pressure	Yes/No	Weight/energy loss	Yes/No
Heart attack	Yes/No	Hernia	Yes/No
Stroke/TIA	Yes/No	Varicose veins	Yes/No
Blood clot/emboli	Yes/No	Allergies, list: _____	Yes/No
Epilepsy/seizures	Yes/No	Pins/metal implants: _____	Yes/No
Thyroid/goiter	Yes/No	Anemia	Yes/No
Infectious diseases	Yes/No	Cancer, type: _____	Yes/No
Diabetes, Type 1 or 2	Yes/No	Chemotherapy/radiation	Yes/No
Arthritis, type _____	Yes/No	Osteoporosis	Yes/No
Gout	Yes/No	Emotional/psychological problems	Yes/No
Sleeping problems	Yes/No	Current pregnancy	Yes/No
Current tobacco use	Yes/No	AIDS/HIV	Yes/No
Multiple Sclerosis	Yes/No	Sexually transmitted disease	Yes/No

Explain any yes answers and give dates: _____

Please complete the other side of this paper

