MEDICAL HISTORY FORM

Diagnosis as stated to you by your physician: ______________________ Date of onset: __________________

How did this injury/exacerbation occur?

Have you been hospitalized for the present condition?  □ Yes □ No If Yes, date: __________________

Have you had surgery for the present condition?  □ Yes □ No If Yes, date: __________________

Have you received previous treatment for this condition?  □ Yes □ No If Yes, date: __________________

If Yes, please summarize: ________________________________________________________________

What would you say is the pain rating for your current condition using a scale of 0-10? (0=no pain, 10=worst pain imaginable) ________________

Do you now or have you ever had the following? Explain

Stroke  □ Yes □ No ________________________________

Heart Disease or Heart Murmur □ Yes □ No ________________________________

High Blood Pressure  □ Yes □ No ________________________________

Asthma  □ Yes □ No ________________________________

Diabetes  □ Yes □ No ________________________________

Epilepsy/Fainting □ Yes □ No ________________________________

Impairment of Vision or Hearing □ Yes □ No ________________________________

Cancer  □ Yes □ No ________________________________

Drug Allergies  □ Yes □ No ________________________________

Osteoporosis □ Yes □ No ________________________________

Orthopedic History—Please give dates & treatments received:

Have you ever sprained, strained, dislocated, or fractured the following:

Neck/Head (Including concussion) ________________________________

Trunk (ribs, vertebrae, sternum) ________________________________

Low Back (vertebrae, discs, nerves) ________________________________

Upper Extremity (shoulder, elbow, wrist, arm) ________________________________

Lower Extremity (hip, leg, knee, ankle, foot) ________________________________

Please list any surgeries that you have had and their dates:

______________________________________________________________

______________________________________________________________

Please list any medication(s) you are presently taking:

______________________________________________________________

______________________________________________________________

Women: Are you pregnant?  □ Yes □ No

I agree that the above information accurately describes my medical history and that should any changed in my medical history occur, I will notify my PT immediately.

Date: _______________ Time: _______________ Signature: _______________

Not part of permanent record. Please discard at discharge.