

PAST MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** ___/___/___ **Date:** ___/___/___

Are you presently working? Yes No; Occupation: _____
 Work Status: Regular Duty Restricted Duty Out of Work Retired Student N/A

Date of injury / onset: ___/___/___ Have you ever had physical therapy for these symptoms before? Yes No

Have you participated in physical therapy over the last year? Yes No; Date of next physician's visit: ___/___/___

Have you fallen over the past year? Yes No; If yes how many times? _____

Check which apply to your symptoms:

- | | | |
|---|---|--|
| <input type="checkbox"/> work related injury | <input type="checkbox"/> recurrence of previous injury | <input type="checkbox"/> chronic condition |
| <input type="checkbox"/> motor vehicle accident | <input type="checkbox"/> injury related to lifting | <input type="checkbox"/> injury related to falling |
| <input type="checkbox"/> cause unknown | <input type="checkbox"/> athletic / recreational injury | <input type="checkbox"/> other: _____ |

Have you had a related surgery? Yes No Briefly explain and give the approximate dates:

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Poor tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies:	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/ Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	Ringling in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes on any of the above, please briefly explain and give the approximate dates:

Is there any other information regarding your past medical history that we should know about?

