



**PAST MEDICAL HISTORY FORM**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Referring Physician:** \_\_\_\_\_

1. Please check if you have ever had:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arthritis/gout                    | <input type="checkbox"/> Low blood sugar/hypoglycemia | <input type="checkbox"/> Infectious disease (Tuberculosis, Hepatitis, HIV) |
| <input type="checkbox"/> Broken bone/fracture              | <input type="checkbox"/> Head injury                  | <input type="checkbox"/> Kidney problems                                   |
| <input type="checkbox"/> Osteoporosis                      | <input type="checkbox"/> Metal implant                | <input type="checkbox"/> Repeated infections                               |
| <input type="checkbox"/> Blood disorders (Anemia)          | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> neurological (stroke, Parkinson, MS, etc.)        |
| <input type="checkbox"/> Seizure/Epilepsy                  | <input type="checkbox"/> Skin diseases                | <input type="checkbox"/> Developmental or growth problem                   |
| <input type="checkbox"/> Heart problems                    | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Circulation/v ascular problems                    |
| <input type="checkbox"/> High blood pressure               | <input type="checkbox"/> Lung problems                | <input type="checkbox"/> Diabetes/high blood sugars                        |
| <input type="checkbox"/> Latex allergy                     | <input type="checkbox"/> Thyroid problems             | <input type="checkbox"/> Ulcer/stomach problems                            |
| <input type="checkbox"/> Mental Illness (Depress, Bipolar) | <input type="checkbox"/> Other: _____                 |  |

2. Within the past 6 months, have you had any of the following symptoms?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Difficulty walking             | <input type="checkbox"/> Urinary problems   |
| <input type="checkbox"/> Heart Palpitations      | <input type="checkbox"/> Joint pain or swelling         | <input type="checkbox"/> Fever/chills/sweats  |
| <input type="checkbox"/> Cough                   | <input type="checkbox"/> Pain at night                  | <input type="checkbox"/> Headache   |
| <input type="checkbox"/> Hoarseness              | <input type="checkbox"/> Difficulty sleeping            | <input type="checkbox"/> Hearing problems   |
| <input type="checkbox"/> Dizziness or blackouts  | <input type="checkbox"/> Loss of appetite               | <input type="checkbox"/> Vision problems  |
| <input type="checkbox"/> Coordination problems   | <input type="checkbox"/> Nausea/vomiting                | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Weakness in arm or legs | <input type="checkbox"/> Bowel problems                 | <input type="checkbox"/> If female: currently pregnant, irregular menstrual cycle, etc. |
| <input type="checkbox"/> Loss of Balance / Falls | <input type="checkbox"/> Unexplained weight loss / gain |   |

3. Have you ever had surgery?  NO  YES If YES, please describe and include dates: \_\_\_\_\_

\_\_\_\_\_

4. Please list all medications (prescription and over the counter) and herbal remedies you are currently taking: \_\_\_\_\_

\_\_\_\_\_

5. Have you had any illness within the last three weeks? (cold, flu, fever, bladder, kidney infections)  NO  YES

If YES, explain: \_\_\_\_\_

6. Do you have any sores that have NOT healed or any change in size, shape or color of a wart or mole?

NO  YES; explain \_\_\_\_\_

7. Do you smoke?  NO  YES If YES, how much? \_\_\_\_\_

8. Do you drink alcohol?  NO  YES If YES,  Daily  Weekly  Occasionally

If YES, what kind?  Hard Liquor  Beer  Wine

Patient Name: \_\_\_\_\_

9. What is your occupation? Or retired from? \_\_\_\_\_

10. Do you do regular exercise?  NO  YES, What type and how often? \_\_\_\_\_

11. Describe the problem for which you are seeking physical therapy. \_\_\_\_\_

12. When did the problem begin (Date): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

13. Have you ever had the problem before?  NO  YES, Explain: \_\_\_\_\_

14. Are you out of work due to your injury?  NO  YES, Give last day worked. \_\_\_\_\_

15. Have you had physical therapy or any other treatment for this condition?  NO  YES; What type, where, and with whom? \_\_\_\_\_

16. Has the current problem or condition for which you are seeking physical therapy affected your ability to perform any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Personal care (bathing, dressing, etc.) | <input type="checkbox"/> Getting into/out of bed, chair, car   | <input type="checkbox"/> Sleep                            |
| <input type="checkbox"/> Sitting                                 | <input type="checkbox"/> Lifting, bending, Kneeling, squatting | <input type="checkbox"/> Standing                         |
| <input type="checkbox"/> Climbing stairs                         | <input type="checkbox"/> Driving                               | <input type="checkbox"/> Running/jumping                  |
| <input type="checkbox"/> Pushing/pulling                         | <input type="checkbox"/> Leisure/Recreation activities         | <input type="checkbox"/> Specific job duties (list) _____ |

17. How do you learn best?  Reading,  Listening,  Demonstration, Other: \_\_\_\_\_

Please rate your overall pain on the scale below: (0 = NO pain; 10 = worst pain possible)

NO Pain		Slight Pain		Mild		Moderate		Severe		Worst Possible	
0	1	2	3	4	5	6	7	8	9	10	
Has NO pain		Hurts a little		Hurts a little more		Hurts even more		Hurts a whole lot		Hurts as much as you can imagine	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(If patient under the age of 18; signature of Parent or Guardian)

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_