MEDICAL HISTORY FORM

1. Name

Last	First	MI

2. Are you: ☐ Right-handed ☐ Left-handed

3. Employment

☐ Work outside of home ☐ Student
☐ Homemaker ☐ Retired
☐ Unemployed

Occupation: _____

How many hours do you spend in computer/desk work per day?_____

How much and how often do you lift objects heavier than 10 pounds?

# of times/day: _____

Average weight of objects lifted: _____

4. Where do you live?

☐ Private home ☐ Private apartment
☐ Board & care / assisted living / group home
☐ Other _____

5. With whom do you live?

☐ Alone ☐ Spouse
☐ Child ☐ Other relative
☐ Pets ☐ Other _____
☐ Personal care attendant
☐ 24-hour ☐ Part-time

6. Does your home have:

☐ Stairs ☐ Ramps
☐ Elevator

7. Do you use:

☐ Cane ☐ Walker ☐ Other _____

8. Do you have any vision or hearing problems? ☐ Yes ☐ No

Do you use:

☐ Glasses/Contacts ☐ Hearing Aid

9. Medications

Do you currently take any prescription medications?

☐ Yes ☐ No If yes, please list: _____

_____

_____

_____

Do you currently take any nonprescription medications?

☐ Antacids ☐ Ibuprofen/ Naproxen
☐ Antihistamines ☐ Laxatives
☐ Aspirin ☐ Tylenol
☐ Decongestants ☐ Vitamins
☐ Herbal supplement

Other _____

10. Health Habits

Please rate your health:

☐ Excellent ☐ Good
☐ Fair ☐ Poor

Do you exercise beyond your daily activities or participate in any hobbies or sports?

☐ Yes

Please describe the exercise, sport or hobby: _____

_____

_____

How many days per week do you exercise or do physical activity? _____

For how many minutes, on an average day? _____

☐ No

Do you currently use or have you previously used tobacco?

☐ Yes Cigarettes, # of packs/day _____

Cigars, # per day _____

Chewing tobacco_____

Year quit: _____

☐ No

How many days per week do you drink beer, wine, or other alcoholic beverages? _____

How many caffeinated beverages do you drink on an average day? _____

Do you have a history of chemical dependency?

☐ Yes ☐ No

11. Within the past year, have you had any of the following medical tests?

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Bone scan
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EKG (electrocardiogram)
☐ EMG (electromyogram)
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction velocity)
☐ Pulmonary function test
☐ Stress test (such as treadmill, bicycle)
☐ X-rays

Therapist comments: _____

_____

_____

_____

Therapist signature: _____

CONTINUE ON OTHER SIDE

12. Medical History

Please check if you have had:	**Yes**	**No**
Allergies		
Arthritis		
Bladder problems (including repeated infections, urinary incontinence, leaking)		
Blood disorders (including hemophilia/anemia)		
Bone/joint infections		
Broken bones/fractures		
Cancer		
Circulation/vascular		
Depression		
Developmental or growth problems		
Diabetes or problems with blood sugar		
Fibromyalgia		
Head injury		
Heart problems (Pacemaker)		
High blood pressure		
Infectious diseases (such as tuberculosis, hepatitis, HIV)		
Kidney problems		
Liver problems		
Lung problems (including asthma)		
Metal implants		
Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)		
Osteoporosis		
Seizures/epilepsy		
Sensitivity to latex rubber		
Skin diseases		
Thyroid problems		
Ulcers/stomach problems		
Other: _____.		

For men:
Have you ever been diagnosed with prostate disease? ☐ Yes ☐ No

For women:
Have you ever been diagnosed with:
☐ Pelvic inflammatory disease? ☐ Endometriosis? ☐ Trouble with your period?
☐ Complicated pregnancies/deliveries?

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

13. Have you ever had surgery?
☐ Yes ☐ No

If yes, please describe and include dates: ____
_____
_____
_____

14. Within the past year, have you had any of the following symptoms?
☐ Bowel problems
☐ Chest pain
☐ Coordination problems
☐ Chronic cough
☐ Difficulty sleeping
☐ Dizziness or blackouts
☐ Fever/chills/ sweats
☐ General malaise
☐ Headaches
☐ Hearing problems
☐ Heart palpitations
☐ Hoarseness
☐ Loss of appetite
☐ Loss of balance or falls
☐ Nausea/ vomiting
☐ Pain during the night
☐ Sexual dysfunction
☐ Shortness of breath
☐ Urinary problems or change in frequency
☐ Vision problems
☐ Weakness in arms or legs
☐ Weight loss/gain

15. Are you currently seeing anyone else for this diagnosis?
☐ Acupuncturist
☐ Athletic trainer
☐ Cardiologist
☐ Chiropractor
☐ Dentist
☐ Family doctor
☐ Internist
☐ Massage therapist
☐ Neurologist
☐ Obstetrician/ gynecologist
☐ Occupational therapist
☐ Orthopedist
☐ Osteopath
☐ Pediatrician
☐ Podiatrist
☐ Primary care physician
☐ Rheumatologist
☐ Other _____

If you see another health professional for this problem, may the physical therapist discuss your case with him or her? ☐ Yes ☐ No

Patient Signature: _____
Date: ___/___/___

Therapist comments: _____
_____
_____
_____

Therapist signature: _____