

**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**

