

PAST MEDICAL HISTORY FORM

To be completed by the patient or guardian prior to starting this physical therapy program:

Patient name _____

Referring Physician _____

Family Physician _____

Type of injury _____

If you answer yes to any of the following questions, please describe.

Yes	No	
___	___	Have you had any diagnostic testing/evaluation related to this injury (ie MRI, etc.)? _____
___	___	Have you had any surgery related to this injury? _____ _____
___	___	Are you allergic to any medications? Which medications and what reactions? _____
___	___	Do you smoke? How many cigarettes per day? _____ How many years have you been smoking? _____
___	___	Do you drink alcoholic drinks more than 2 to 3 times per week? _____
___	___	Have you ever had surgery? What operations and when? _____ _____
___	___	Are you presently taking medication? What medication and how often? _____ _____
___	___	Have you gained or lost weight since your injury and how much? _____
___	___	Are you taking any diet pills? What kind and how often? _____
___	___	Are you taking any recreational drugs? What kind and how often? _____
___	___	Have you had any psychological treatment in the past? _____

Have you ever had any of the following?

Yes	No		Yes	No	
___	___	Heart disease _____	___	___	Drug dependency _____
___	___	Heart Attack/angina _____	___	___	Back pain _____
___	___	Stroke _____	___	___	Easy bruising/bleeding _____
___	___	Frequent headaches _____	___	___	Kidney disease _____
___	___	Neurological disease or nervous disorder _____	___	___	Hepatitis _____
___	___	Asthma or frequent wheezing _____	___	___	Diabetes _____
___	___	Lung disease _____	___	___	Sickle Cell Anemia _____
___	___	Blood transfusion _____	___	___	High Blood Pressure _____
___	___	History of ulcers _____	___	___	Thyroid disease _____
___	___	Mental disorder _____	___	___	Pacemaker _____
___	___	Cancer _____			

I have read and understand the above questions.

Signature of patient or responsible party Relationship Date

*****If patient is under 18*****

*I _____ (Parent or legal guardian) give my permission for _____ who is under 18 years of age, to be seen and treated without me present.