PATIENT MEDICAL HISTORY

DATE: _____ **NAME:** _____ **AGE:** _____

DATE OF BIRTH: _____ **REFERRING PHYSICIAN:** _____

ADDRESS: _____ **PHONE NUMBER:**_____

EMAIL ADDRESS: _____ **WEIGHT:** _____ **HEIGHT:**_____

REASON FOR VISIT:_____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THE CONDITIONS YOU HAVE OR HAD.)

- ☐ NONE
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE/TIA
- ☐ OBSTRUCTIVE SLEEP APNEA
- ☐ CORONARY ARTERY DISEASE
- ☐ DEPRESSION
- ☐ CANCER (TYPE)_____
- ☐ ANXIETY
- ☐ BLEEDING DIFFICULTIES
- ☐ HEPATITIS A, B, OR C
- ☐ HIV
- ☐ DIABETES-DIET CONTROLLED
- ☐ DIABETES-ORAL MEDS
- ☐ DIABETES-ON INSULIN
- ☐ OTHER _____
- ☐ HIGH COLESTEROL
- ☐ SEIZURE
- ☐ LOSS OF CONSCIOUSNESS
- ☐ ARTHRITIS (TYPE)_____
- ☐ ASTHMA
- ☐ EMPHYSEMA
- ☐ OSTEOPOROSIS
- ☐ ALLERGIES _____

PAST SURGICAL HISTORY: _____

_____

HAVE YOU BEEN SEEN BY ANOTHER PHYSICAL THERAPIST, CHIROPRACTOR AND/OR USED HOME HEALTH PT SERVICES THIS YEAR? IF SO, WHO & HOW MANY VISITS: _____

MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

RECENT IMAGING: _____

_____

EMERGENCY CONTACT/INDIVIDUALS AUTHORIZED TO DISCUSS TREATMENT AND/OR PATIENT BILLING:

NAME: _____ **RELATIONSHIP:** _____ **CONTACT #:** _____

NAME: _____ **RELATIONSHIP:** _____ **CONTACT #:** _____

NAME: _____ **RELATIONSHIP:** _____ **CONTACT #:** _____

PLEASE INCLUDE ANY ADDITIONAL MEDICATIONS, SURGICAL HISTORY, MEDICAL CONCERNS, OR ANY ADDITIONAL INFORMATION YOU WOULD LIKE YOUR PT TO KNOW ON THE BACK OF THIS FORM.