A-1 PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

Name:_____ Age: _____
Last First M. I.

Reason for Visit: _____

Allergies:

_____

_____

Medication List:

_____

_____

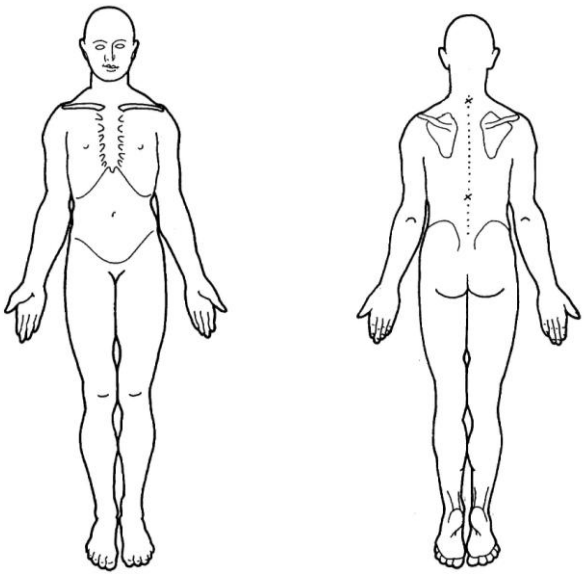
_____

_____

Please mark the areas where and what you feel symptoms on the chart:

Sharp/Shooting Pain ___ Numbness ___

Dull/aching Pain ___ Tingling ___



Family History:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Stroke
- ☐ Epilepsy/Convulsions
- ☐ TB and/or Exposure
- ☐ Gout
- ☐ Cancer; Specify Type:_____
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Thyroid Issues
- ☐ Hepatitis
- ☐ Alcoholism
- ☐ Mental Illness
- ☐ Kidney Disease
- ☐ Migraines

Social History:

Cigarette/Tobacco Use: ___YES ___NO Age Started ___ Average Number/Day_____ Age Stopped ___

Alcohol Use: ___ YES ___ NO Average Drinks / Day _____ Frequency / Week _____

Caffeine:(Tea, Coffee, Soda, etc) ___YES ___ NO Average Drinks/Day _____ Frequency/Week _____

Other Substances: _____

Exercise: Type _____ Frequency _____

Work: ___Employed ___Unemployed ___Retired ___Unable to Work Employer_____

Female History:

Number of Children ____ Number of Pregnancies ____ Sexually Active ___ YES ___NO

___Menopause ___Hysterectomy ___Birth Control Last PAP Smear: _____ Last Mammogram: _____

Allergies:

Are you allergic to any medications, dyes, peanuts, or shellfish? ___YES ___ NO

Drug Allergies/Type of Reaction _____

Signature:_____ **Date:**____/____/_____

Infectious Disease	Past History	Current History	Never
Chicken Pox	☐	☐	☐
Malaria	☐	☐	☐
Mononucleosis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Scarlet Fever	☐	☐	☐
Tuberculosis	☐	☐	☐

Eyes, Ears, Nose,Throat			
Deafness	☐	☐	☐
Hearing Loss	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Sinus Disease	☐	☐	☐
Glasses/Contact Use	☐	☐	☐

Other Visual Problems_____
Describe_____

Cardiopulmonary			
Asthma	☐	☐	☐
Bronchitis/Pneumonia	☐	☐	☐
Fainting	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Murmur	☐	☐	☐
High Blood Cholesterol	☐	☐	☐
High Blood Pressure	☐	☐	☐
Mitral Valve Prolepses	☐	☐	☐

Gastroenteric			
Crohn's Disease	☐	☐	☐
Ulcerative Colitis	☐	☐	☐
Reflux/GERD/Ulcer	☐	☐	☐
Gall Bladder Disease	☐	☐	☐
Hepatitis - Type_____	☐	☐	☐
Hernia	☐	☐	☐
Irritable/Spastic Bowel	☐	☐	☐
Regular Laxative Use	☐	☐	☐
Pancreatitis	☐	☐	☐

Urinary			
Cystitis/Bladder Infection	☐	☐	☐
Kidney Disease	☐	☐	☐
Kidney Infection	☐	☐	☐
Kidney Stones	☐	☐	☐

Musculoskeletal	Past History	Current History	Never
Arthritis	☐	☐	☐
Bone or Joint Deformity	☐	☐	☐
Broken Bones	☐	☐	☐
Rheumatoid Disorder	☐	☐	☐
Other	☐	☐	☐

Hematologic or Oncologic			
Anemia	☐	☐	☐
Hemophilia	☐	☐	☐
Leukemia or Lymphoma	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Other Blood Disorder	☐	☐	☐
Cancer_____	☐	☐	☐

Neuropsychiatric			
ADD/ADHD	☐	☐	☐
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Suicidal Thoughts or Acts	☐	☐	☐
Drug Addiction/Abuse	☐	☐	☐
Epilepsy (Seizures)	☐	☐	☐
Recurrent Headaches	☐	☐	☐
Serious Head Injury	☐	☐	☐

Metabolic			
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐

Birth Defects
Describe_____

Sexual Health			
Positive HIV Antibody	☐	☐	☐
Abnormal PAP Smear	☐	☐	☐
Breast Lump	☐	☐	☐
DES Exposure (Maternal)	☐	☐	☐
Menstrual Abnormalities	☐	☐	☐
Testicular Lump	☐	☐	☐
Undescended or Absent Testicle	☐	☐	☐
Hydrocele or Varicocele	☐	☐	☐

Other Significant Medical Issues:_____
Hospitalization Dates:_____
Surgery History:_____

Signature:_____ **Date:** _____