DARBY PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Date:_____

Circle Yes or No

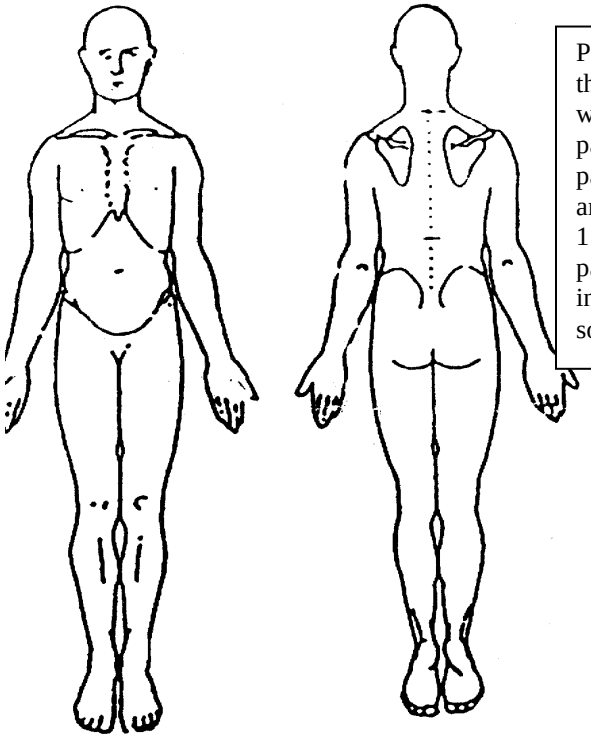
Have you or any immediate family member ever been told you have . . .

	SELF		FAMILY	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
Angina/Chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Bleeding disorders?	Yes	No	Yes	No

In the past 3 months have you had or do experience:

A change in your health? Yes No
Nausea/Vomiting? Yes No
Fever/Chills/Sweats? Yes No
Unexplained weight change? Yes No
Numbness or tingling? Yes No
Changes in appetite? Yes No
Difficulty swallowing? Yes No
Changes in bowel/bladder function? Yes No
Shortness of breath? Yes No
Dizziness? Yes No
Upper respiratory infection? Yes No
Urinary tract infection? Yes No

Please rate your pain over the last 24 hours
Circle your answer…0 1 2 3 4 5 6 7 8 9 10



Please mark on the body chart where you have pain. If you have pain in multiple areas please put a 1 by your worst pain and 2 by less intense pain and so on.

Do you have any allergies to medications?
Yes…….No
List _____

List previous surgeries and dates._____
_____
_____

List medications you are currently using:_____
_____
_____

Do you have a history of:

Allergies/asthma? Yes No
Headaches? Yes No
Bronchitis? Yes No
Kidney disease? Yes No
Rheumatic fever? Yes No
Ulcers? Yes No
Sexually transmitted disease? Yes No
Seizures? Yes No
Do you have a pacemaker? Yes No
Do you have any metal in your body? Yes No
Where? _____

Are you currently:

Pregnant? Yes No
Depressed? Yes No
Under Stress? Yes No

Are your symptoms: (check one)
□□ Getting worse □ The same: how long? _____
□□ Improving

How are you able to sleep at night? (check one)
□□ Fine □□ Moderate difficulty
□□ Only w/ Medication

Check all that apply…..
Do you have a problem with…?
□□ Hearing □□ Vision
□□ Speech □□ Communication

Have you consulted an attorney for your current Problem? Yes No

Preferred learning method….
□□ Verbal □ Written □ Demonstration

Do you, or have you in the past smoked tobacco?
Yes No
If yes, _____ packs X _____ years
Last tobacco use _____

Do you drink alcoholic beverages?... Yes No
If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____