CORVALLIS 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 . . .

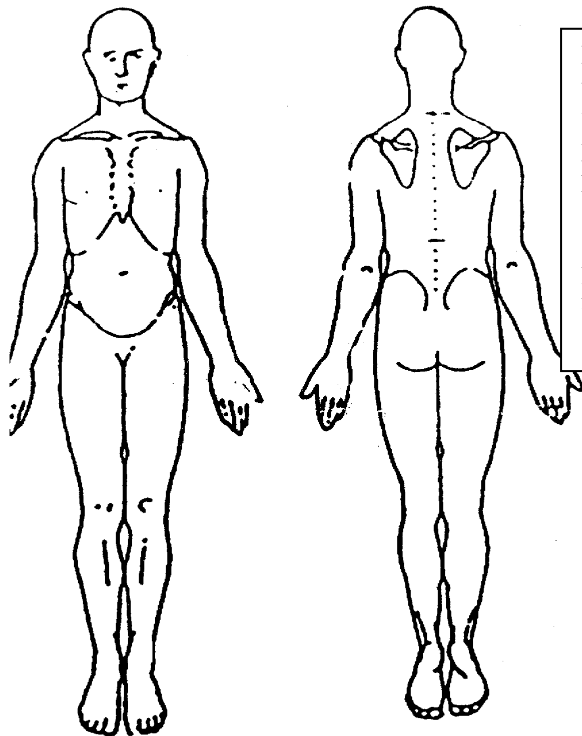
	SELF		FAMILY	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
Angina/Chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Bleeding disorders?	Yes	No	Yes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