

STEVENSVILLE PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date: _____

Circle Yes or No

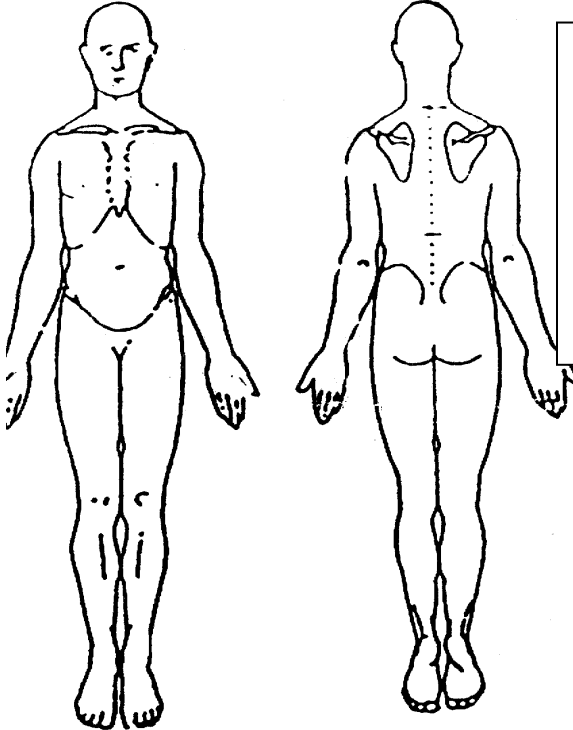
Have you or any immediate family member ever been told you have . . .

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

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

- A change in your health?.....YesNo
- Nausea/Vomiting?YesNo
- Fever/Chills/Sweats?YesNo
- Unexplained weight change?YesNo
- Numbness or tingling?YesNo
- Changes in appetite?YesNo
- Difficulty swallowing?YesNo
- Changes in bowel/bladder function?YesNo
- Shortness of breath?YesNo
- Dizziness?YesNo
- Upper respiratory infection?YesNo
- Urinary tract infection?YesNo

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? YesNo
- Headaches? YesNo
- Bronchitis? YesNo
- Kidney disease? YesNo
- Rheumatic fever? YesNo
- Ulcers? YesNo
- Sexually transmitted disease? YesNo
- Seizures? YesNo
- Do you have a pacemaker? YesNo
- Do you have any metal in your body? YesNo
Where? _____

Are you currently:

- Pregnant? YesNo
- Depressed? YesNo
- Under Stress? YesNo

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? YesNo

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?... YesNo

If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____