

Patient Name: _____

MEDICAL HISTORY FORM

PLEASE PUT AN **X** IF YOU HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING:

- | | | | |
|--|------------------------------------|--|---|
| <input type="checkbox"/> STROKE | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> METAL IMPLANTS | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> CARDIAC PROBLEMS | <input type="checkbox"/> SURGERY | <input type="checkbox"/> DIFFICULTY WALKING | <input type="checkbox"/> SMOKE CIGARETTES |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> CANCER | <input type="checkbox"/> CURRENTLY PREGNANT | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> DIABETES | <input type="checkbox"/> ALLERGY TO MEDICATION | <input type="checkbox"/> VERTIGO |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> ALLERGY TO LATEX | <input type="checkbox"/> FRACTURES |

Please answer the following:

Date of injury:

Did this injury happen at work? yes no

Did this injury happen in a car accident? yes no What state?.....

Have you received prior treatment for this problem? yes no

If yes, when, what and where? *(please include home healthcare)*.....

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Have you been in home healthcare for any other problems? If yes, when, what, where?.....

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List any other medical problems or surgeries (please explain):.....

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Please list any medications you are currently taking:.....

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When is your next scheduled appointment with the doctor who referred you to physical therapy?.....

.....

PATIENT'S SIGNATURE DATE.....