Past Medical History

Patient name:_____________________________

Please complete this form. The purpose of this questionnaire is to help us perform a thorough evaluation and further understand your condition.
Please note that this form is considered part of your medical records and will be kept private and confidential.

***Have you received Physical Therapy in the past year? YES or NO (circle one)**
If YES, how many visits have you had? _______________________

Have you ever suffered or have been told that you have:			
High blood pressure	**YES**	**NO**	
Heart problems	**YES**	**NO**	
Lung problems	**YES**	**NO**	
Head injury	**YES**	**NO**	
Multiple sclerosis/Parkinson's Disease	**YES**	**NO**	
Stroke	**YES**	**NO**	
Liver problems	**YES**	**NO**	
Thyroid problems	**YES**	**NO**	
Blood disorders	**YES**	**NO**	
Diabetes (high blood sugar)	**YES**	**NO**	
Low blood sugar	**YES**	**NO**	
Cancer	**YES**	**NO**	
Arthritis	**YES**	**NO**	
Osteoporosis	**YES**	**NO**	
Circulatory or vascular problems	**YES**	**NO**	
Broken bones (fractures)	**YES**	**NO**	
Other orthopedic problems	**YES**	**NO**	
Chronic pain	**YES**	**NO**	
Ulcers/stomach problems	**YES**	**NO**	
Chronic migraines	**YES**	**NO**	
For men only:			
• Prostate disease	**YES**	**NO**	
For women only:			
• Pelvic inflammatory disease	**YES**	**NO**	
• Endometriosis	**YES**	**NO**	
• Complicated pregnancies	**YES**	**NO**	
• Trouble with your period	**YES**	**NO**	
• Are you currently pregnant?	**YES**	**NO**	
PLEASE TURN OVER			**PLEASE TURN OVER**

Have you recently experienced:			
Weight loss/gain	**YES**	**NO**	
Pain at night	**YES**	**NO**	
Fatigue/malaise	**YES**	**NO**	
Difficulty sleeping	**YES**	**NO**	
Joint pain and/or swelling	**YES**	**NO**	
Urinary or bowel problems	**YES**	**NO**	
Nausea and vomiting	**YES**	**NO**	
Numbness or tingling, if yes where?	**YES**	**NO**	
Weakness in your arms or legs	**YES**	**NO**	
Coordination problems	**YES**	**NO**	
Difficulty walking	**YES**	**NO**	
Dizziness or loss of consciousness	**YES**	**NO**	
Chest pain	**YES**	**NO**	
Heart palpitations	**YES**	**NO**	
Shortness of breath	**YES**	**NO**	
Difficulty swallowing	**YES**	**NO**	
New onset of headaches	**YES**	**NO**	
Visual problems	**YES**	**NO**	
Hearing problems	**YES**	**NO**	
Do you:			
Smoke	**YES**	**NO**	
• If yes, how much?_____ppd			
Drink alcohol	**YES**	**NO**	
• If yes, how much?_________			
Have any significant family history of illness or disease	**YES**	**NO**	
Any falls in the past 12 months. If yes, How many times?	**YES**	**NO**	

Height:_____________ Weight: ____________
(*Attn Medicare patients- Height/Weight is required to be documented by Medicare)

Please list any medications that you are currently taking, Dosage, Frequency & How taken?
(*Attn Medicare patients- a list of medications is required to be documented by Medicare)
____
____
____

Have you had surgery or been hospitalized in the past? YES NO
Date/reason :____
____

Who is the primary physician that you see most often?________________________

How were your referred to us? (Please check) Doctor □ ____________________ Friend/prior patient□______________________ Insurance company □ Internet □ Yellow Pages □
Other□___________________