PATIENT MEDICAL HISTORY

Today's Date: ____________________

_____________________________________ ________________ _______________________
Patient's Name (Last, First, MI) Date of birth Social security #
Height ____________________ Weight ___________________
Describe your general health: (circle one) Excellent Good Fair Poor

Do you have any history of: (please check all that apply)

____ Abnormal bleeding
____ Arthritis
____ Asthma
____ Cancer
____Chest Pain
____Depression
____ Diabetes
________ Digestion difficulty
________ Heart Disease
________ Headaches
________ High Blood Pressure
________ Kidney Disease
________Lung Disease
________ Osteoporosis
________ Phlebitis
________Seizures
________Shortness of Breath
________Skin Disease
________Stroke
________Thyroid problems
________ Other:

Women, are you pregnant?_______________________
Men, any history of prostate disease?___________________________________
Other medical conditions: (Please list)
____
____

Previous surgeries and year:
____
____

Previous hospitalizations other than for surgery and the year:
____
____

Current Medication:
____
____
____

Are you allergic to any medications? Yes ___ No _____ If yes, please list: __________________________
____

Are you allergic to latex? Yes _____ No______
Any other allergies? Yes _____ No _______ If yes, please list: _______________________________
____

Do you use tobacco? Yes____ No___ If Yes, how much? ______________________________________

Is there any other medical history you would like your P.T. to know? ____________________________
____

___________________________________ _____________________ _____________________
Patient's Signature Date Reviewed by: