farese PHYSICAL THERAPY

Patient Medical History Form

1. Name ____ Age ___________ Account No ________________________
2. Occupation ________________________Type of Work, examples: lifting, sitting, standing, etc.___________________________
3. Height ___________________ Weight _____________ Do you Smoke ☐ Yes ☐No
4. Past Medical History – Do you have a history of:

High Blood Pressure	☐ Yes ☐No	Pacemaker	☐ Yes ☐No	Currently Pregnant	☐ Yes ☐No
Heart Condition	☐ Yes ☐No	Seizures	☐ Yes ☐No	Diabetes	☐ Yes ☐No
Strokes	☐ Yes ☐No	Cancer	☐ Yes ☐No	HIV or AIDS	☐ Yes ☐No
Osteoarthritis	☐ Yes ☐No	Allergies	☐ Yes ☐No	Fibromyalgia	☐ Yes ☐No
Lupus	☐ Yes ☐No	Internal Fixation Devices ☐ Yes ☐No (if yes, specify)______________________			

5. Previous medical problems or surgeries? ☐ Yes ☐No If yes, please specify _______________________________________

   ____
6. Tests while in the hospital or outpatient? Example: CAT SCAN, EMG, EKG, MRI, X-RAYS

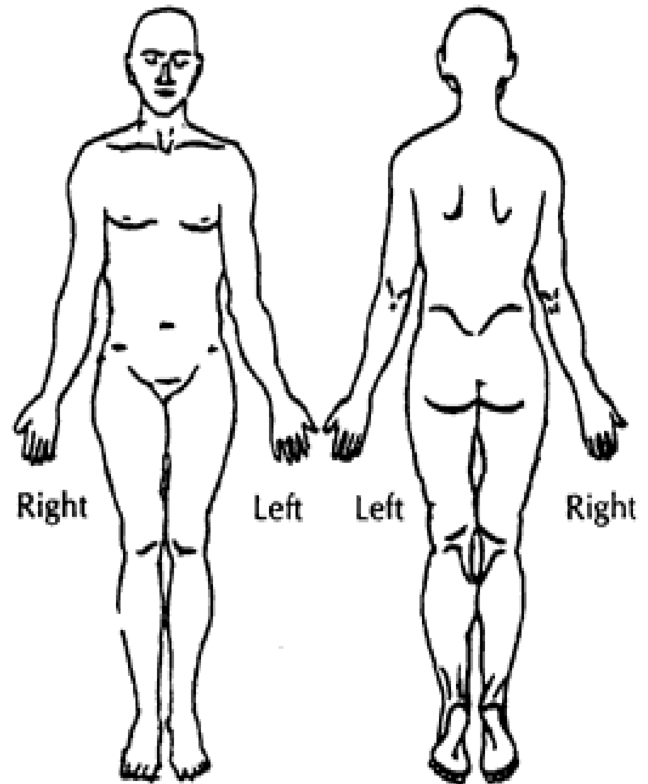
   If yes, please specify ____
7. Previous orthopedic problems? If yes, please specify ____
8. Medications? What type? What for? ____
9. Regular Exercise/activity level ______ 0-days/week _______1-2 days/ week _______3-5 days/week _____6-7 days/week
10. Types of activities? ____
11. Doctors: Orthopedic ____ Primary ___________________________
12. I am aware of the diagnosis and prognosis for which I have been referred for physical therapy treatments as discussed with my physician?
    ☐Yes ☐No
13. Is it necessary for someone to assist you with daily tasks?
    ☐Yes ☐No
14. In what ways do you feel your injury or condition has affected you?

    ____

    ____

    ____

    ____
15. Patient's Signature X______________________ Date_________



16. Indicate on the diagram above:

    Pain= X Numbness/Tingling = /

    Burning = O Cramping = ^

Therapist's Plan

☐ Will send in request for records

____

☐ Will review hospital/out patient/doctor office record.

☐ Not necessary at this time to request/review records.

Therapist's Signature ___________________________ Date ____________