PATIENT MEDICAL HISTORY

Name _____ Physician _____

Have you had any of the following in the last year?

	YES	NO
Allergies		
Anemia		
Appetite change		
Arthritis		
Asthma, Bronchitis, Emphysema		
Blood Clot/Emboli		
Bowel/Bladder Problems		
Bruising/Bleeding easily		
Chest pain/Discomfort		
Chills		
Decreased balance in dark		
Diabetes		
Double vision		
Ear pain/inflammation		
Ear Pressure		
Eye inflammation/pain		
Falls		
Fatigue		
Fever		
Gout		
Headaches		
Hearing changes		

	YES	NO
Heart Attack		
Heart Palpitations		
High Blood Pressure		
High Cholesterol		
Joint replacements		
Low Blood Pressure		
Migraines		
MuscleWeakness		
Osteoporosis		
Polio		
Ringing in Ears/Tinitus		
Shortness of Breath		
Skin Changes		
Sleep disturbance		
Stroke		
Syncope (fainting)		
Tremors		
Unexplained wt. Loss		
Vertigo (dizziness)		
Visual changes		
Vomiting		

Daily Medications (Name & Dosage)

Surgical History

Additional information pertinent to your care, including recent medical tests or consultations:

What are your goals for your physical therapy treatment?

Signature _____ Date _____