PATIENT MEDICAL HISTORY

Answers to the following questions will assist the therapist in providing a safe and effective treatment program.

Patient Name: _____ Age:_____

Referring Physician: _____ Primary Care Physician: _____

Problems to be treated:

_____

Have you had treatment for this problem before? [ ] YES [ ] NO
If yes, state where: _____ Approximately When: _____
Treatment given:

_____

Have you had surgery associated with this problem? [ ] YES [ ] NO
If YES, please list the approximate date and type of surgery:

_____

List any other major illness or surgery that has occurred in the past year:

_____

Please list any current medications you are taking:

_____

_____

Please list any allergies (latex, drug etc…) and describe any drug reactions:

_____

_____

Please circle any of the following you may have/wear:
Dentures Pacemaker Metal/Foreign Object Implants

Are you pregnant? [ ] YES [ ] NO

Please circle all that apply:

AIDS	**Diabetes**	**Motor Vehicle Accident**
Allergies	**Drug Abuse**	**Psychiatric Treatment**
Anemia	**Emphysema**	**Rheumatic Heart Disease**
Arthritis	**Fainting**	**Seizures**
Asthma	**Fractures**	**Shortness of Breath**
Back Trouble	**Glaucoma**	**Sinusitis**
Bleeding Disease	**Heart Disease**	**Stomach Ulcers**
Bronchitis	**Heart Attack**	**Stroke**
Cancer	**Heart Murmur**	**Swelling of Hands/Feet**
Chest Pain	**Hepatitis**	**Thyroid Disease**
Congenital Heart Defect	**High Blood Pressure**	**Tuberculosis**
Congestive Heart Failure	**Kidney Disease**	**Rheumatic Fever**
Convulsions	**Liver Disease**	

Other _____

Are you currently enrolled in Physical Therapy or Occupational Therapy at Home or another facility?
[ ] YES [ ] NO

If YES, please list reasons why _____

_____

What do you expect to gain/accomplish in receiving therapy? _____

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS CORRECT

_____ _____
Patient Name **Date**