MEDICAL HISTORY FORM

Patient Name: _____ Today's Date: _____
Referring Physician's Name: _____ Date of Injury or Onset: _____
Primary Care Physician's Name: _____ Are you presently working? Yes No
Cause of Injury or Onset: _____ Date of Next MD Appt: _____

What is your reason for attending physical therapy: _____

Because of your problem, what specific activities are you having difficulty with?

1. _____
2. _____
3. _____

What are your personal goals/outcomes you hope to achieve from physical therapy?

1. _____
2. _____
3. _____

Describe your general health: (Circle One) Excellent Good Fair Poor
Do you use tobacco? (Circle One) Yes or No If yes, how much? _____
Have you recently been hospitalized or had surgery? Yes No If yes, when _____
And why _____

Have you had prior physical/occupational therapy for this condition? Yes or No
What was done? / What were the results? _____

Have you had prior physical therapy this calendar year? Yes or No
Was it received at: (Circle One) Hospital or Outpatient Center or Home Health
For how long? _____

Current Medications: _____
_____

Allergies: Medication _____ Reaction _____ Other _____ Reaction _____

Are you allergic to latex? (Circle One) Yes or No If yes, what is the reaction _____
Are you allergic to Dexamethasone? Yes or No If yes, what is the reaction _____
Dexamethasone is a corticosteroid that can be applied to a pad and placed on the skin. When the pad is electrically activated it helps "push" the medicine into the affected area with the objective of reducing swelling and pain.

Do you now or have ever had any of the following conditions? (Please check all that apply)

- o Anemia
- o Arthritis
- o Cancer
- o Cardiovascular Problems
- o Holter Monitor – currently wearing?
  - o Pacemaker
- o High Blood Pressure
- o Low Blood Pressure
- o Currently Pregnant
- o Diabetes
- o Depression
- o Dizziness/Fainting
- o Fractures
- o Headaches
- o Hepatitis/HIV
- o Kidney Problems
- o Osteoporosis
- o Respiratory Problems
- o Asthma
- o COPD
- o Seizures
- o Thyroid Problems
- o MRSA (Methicillin Resistant Staphylococcus Aureus)

If checked any above, explain: _____
Any other medical problems: _____
_____

Signature of Patient/Guardian _____
Reviewed by: _____ Date: _____