

PATIENT MEDICAL HISTORY FORM



DO YOU HAVE OR HAVE HAD:

THERAPIST COMMENTS:

- 1. YES NO High or low blood pressure
2. YES NO Heart problems (murmur, abnormal rate, rheumatic fever, etc)
3. YES NO A Pacemaker
4. YES NO Angina (chest pain)
5. YES NO Shortness of breath - recurrent
6. YES NO Asthma, allergies, sinus problems / infections
7. YES NO Lung problems (bronchitis, emphysema, pneumonia)
8. YES NO Recent unintentional weight gain / loss, loss of appetite, prolonged nausea vomiting
9. YES NO Liver disease (hepatitis, jaundice)
10. YES NO Kidney or bladder problems (urgency, frequency, bloody, incontinence, retention)
11. YES NO Bowel problems (constipation, diarrhea, bloody, incontinence)
12. YES NO Thyroid problems (hypo or hyper)
13. YES NO Diabetes (high blood sugar or low blood sugar)
14. YES NO Cancer
15. YES NO Osteoporosis or osteopenia
16. YES NO Headaches (recurrent or chronic)
17. YES NO A Stroke, head injury or concussion / loss of consciousness
18. YES NO Depression
19. YES NO Any muscular disease (multiple sclerosis, polio, cerebral palsy, ALS, etc)
20. YES NO Fainting spells, seizures, epilepsy, or dizziness
21. YES NO A history of many fractures, frequent joint sprains, frequent muscle sprains
22. YES NO A history of frequent or chronic bursitis, tendinitis
23. YES NO Arthritis or any unusual joint pain or swelling
24. YES NO A history of fibromyalgia, or chronic fatigue syndrome
25. YES NO A history of neck or back pain (especially chronic or recurring)
26. YES NO Skin conditions (shingles, eczema, psoriasis, rashes)
27. YES NO Infectious diseases (MRSA, C-difficile, tuberculosis)
28. YES NO Smoking history
29. YES NO Hearing Loss
30. YES NO Do you wear contacts or eyeglasses
31. YES NO Allergies to medications / food / other: _____

CURRENT SYMPTOMS:

- YES NO Numbness or tingling
YES NO Weakness or fatigue
YES NO Ankle / leg swelling
YES NO Cold extremities
YES NO Hoarseness
YES NO Coordination problems
YES NO Night sweats / fever / chills
YES NO Sleeplessness
YES NO Loss of balance or falls
YES NO Blurred or double vision
YES NO Difficulty swallowing
YES NO Chronic cough
YES NO Concentration problems
YES NO Memory Loss

WHAT MAJOR SYMPTOMS BRINGS YOU HERE TODAY? _____

WOMEN ONLY:

YES NO Are you pregnant or possibly pregnant? YES NO Have you had a hysterectomy / post menopause?

HOW DID YOU HEAR ABOUT OUR CLINIC? MD ____, Physician Asst ____, Nurse Practitioner ____, Doctor's Secretary ____, Friend ____, Relative ____, Prior Patient ____, Phone Book ____, Mailing ____

DATE OF INJURY / ONSET: _____ DATE OF SURGERY (if applicable): _____

Current Medications (include non-prescription and supplements) _____

Surgery History (list all surgeries and approximate dates) _____

NAME: (print) _____ DATE: _____

All of the information about is true and complete. SIGNATURE: _____