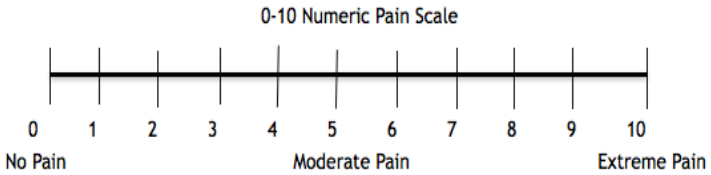
LATTIMORE
physical therapy & sports rehabilitation

PATIENT MEDICAL HISTORY FORM

What major symptoms bring you here today? _____

Date of Injury or Onset: _____ **Date of Surgery (if applicable):** _____

PLEASE CIRCLE APPROPRIATE PAIN LEVEL:



DO YOU HAVE OR HAVE HAD:

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
    Type: _____
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 unusual joint pain or swelling
24. YES NO A history of fibromyalgia, or chronic fatique 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 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

WOMEN ONLY:

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

Current Medications (include non-prescription and supplements) – please include dosage, times per day and how medication is administered

_____
_____
_____
_____

Surgical History (list all surgeries and approximate dates) _____
_____
_____

PATIENT NAME / GUARDIAN (print) _____ **DATE:** _____

All of the information above is true and complete.
PATIENT NAME / GUARDIAN SIGNATURE: _____
Updated - please initial and date: _____