

# MEDICAL HISTORY

Patient Name \_\_\_\_\_

Referring Physician \_\_\_\_\_

Current Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of main complaint (describe present injury/illness, treatment received, surgery if any): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of injury or onset of symptoms: \_\_\_\_\_

Please mark affected area on Body Chart.

Is this problem getting:

Better \_\_\_\_\_ Worse \_\_\_\_\_ Staying the same \_\_\_\_\_

What physical restrictions have you experienced because of this? \_\_\_\_\_

\_\_\_\_\_

Did this injury occur at work? \_\_\_\_\_ Have you received therapy treatment? \_\_\_\_\_

**Do you have /or had any of the following conditions, ( X any that are applicable):**

High Blood Pressure \_\_\_\_\_ Thyroid Problems \_\_\_\_\_ Chest Pains \_\_\_\_\_ Epilepsy/Seizures \_\_\_\_\_

Heart Attack \_\_\_\_\_ Heart Disease \_\_\_\_\_ Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_ Pacemaker \_\_\_\_\_ Allergies \_\_\_\_\_ Asthma \_\_\_\_\_

Swollen Ankles \_\_\_\_\_ Heart Murmur \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Leukemia \_\_\_\_\_

Fainting \_\_\_\_\_ Radiation Therapy \_\_\_\_\_ Anemia \_\_\_\_\_ Angina \_\_\_\_\_

Hepatitis/Jaundice \_\_\_\_\_ Joint Replacement \_\_\_\_\_ Liver Disease \_\_\_\_\_ Low Blood Pressure \_\_\_\_\_

Emphysema \_\_\_\_\_ Cancer \_\_\_\_\_ Arthritis \_\_\_\_\_ Ulcers \_\_\_\_\_ Kidney Disease \_\_\_\_\_

Other \_\_\_\_\_

**DO NOT RESUSCITATE** \_\_\_\_\_

List all major surgical procedures in the past five years: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke? \_\_\_\_\_ How long? \_\_\_\_\_ How much? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ How often? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

\_\_\_\_\_

