Care Medical Group

PHYSICAL THERAPY MEDICAL HISTORY

1.

Last Name

First Name M.I.

2. Phone:

3. Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐☐☐

4. Sex: ☐ Male ☐ Female

5. Are you: ☐ Right-handed ☐ Left-handed

6. Employment/Work (Job/School/Play)

☐ Working full-time outside of home
☐ Working part-time outside of home
☐ Working full-time from home
☐ Working part-time from home
☐ Homemaker
☐ Student
☐ Retired
☐ Unemployed

Occupation:

7. SOCIAL/HEALTH HABITS

Smoking

Smoke tobacco? ☐ No, never smoked ☐ Yes
☐ Cigarettes: # of packs per day
☐ Cigars / Pipes # per day

Smoked in past? ☐ Yes Year quit: ☐☐☐☐

Exercise

Do you exercise beyond normal daily activities and chores?
☐ Yes. Describe:

On average, how many days per week do you exercise or do physical activity?
For how many min. on an average day?
☐ No

8. FAMILY HISTORY (Indicate whether mother/father, brother/sister, aunt/uncle, grandmother/grandfather, and age of onset if known)

Heart disease:
Hypertension:
Stroke:
Diabetes:
Cancer:
Arthritis:
Osteoporosis:
Other:

9. MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

☐ Allergies **(Latex)**
☐ Arthritis
☐ Multiple sclerosis
☐ Broken Bones/fractures
☐ Muscular dystrophy
☐ Parkinson disease
☐ Osteoporosis
☐ Seizures/epilepsy
☐ Blood disorders
☐ Circulation/vascular problems
☐ Heart problems
☐ Thyroid problems
☐ High blood pressure
☐ Cancer
☐ Infectious disease
☐ Lung problems
(eg, tuberculosis, hepatitis
☐ Kidney problems
☐ Stroke
☐ Diabetes/ high blood sugar
☐ Repeated infections
☐ Depression
☐ Low blood sugar/ hypoglycemia
☐ Head injury
☐ Other:

Within the past year, have you had any of the following symptoms? (Check all that apply.)

☐ Chest pain
☐ Difficulty sleeping
☐ Heart palpitations
☐ Loss of appetite
☐ Cough
☐ Nausea/vomiting
☐ Shortness of breath
☐ Weight loss/gain
☐ Dizziness or blackouts
☐ Fever/chills/sweats
☐ Coordination problems
☐ Headaches
☐ Weakness in arms or legs
☐ Loss of balance
☐ Difficulty walking
☐ Pain at night
☐ Joint pain or swelling
☐ Other:

Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe, and include dates:

Month Year
☐☐ ☐☐☐☐
☐☐ ☐☐☐☐

For men only: Have you been diagnosed with prostate disease?
☐ Yes ☐ No

For women only:
Have you been diagnosed with:
Trouble with your period? ☐ Yes ☐ No
Pregnant or think that you might be pregnant? ☐ Yes ☐ No

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