Care Medical Group

PHYSICAL THERAPY MEDICAL HISTORY

1.

Last Name

First Name M.I.

2. Phone:

3. Email address:

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

5. Sex: ☐ Male ☐ Female

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

7. 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:

8. 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

9. 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:

10. 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 (eg, tuberculosis, hepatitis
- ☐ Lung problems
- ☐ 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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