MEDICAL HISTORY

Patient Name: ____ Age: ____________________

Type of Injury/ Condition: ____

Onset/Date of Injury: ____

If this injury is work related, please describe: ____

Type of Surgery and Date (if applicable): ____

Next Doctor's Appointment: ____

Have you received physical therapy for your current condition? ____ Yes ____No

If yes, when and where, and how long?

____

____

Do you have a history of the following?

	Yes	**No**
Diabetes	____	____
Heart Disease	____	____
Cardiac Pacemaker	____	____
Cancer	____	____
Stroke	____	____
High Blood Pressure	____	____
Lung Disease	____	____

Have you recently experienced any of the following?

	Yes	No		Yes	No
Persistent pain at night	____	____	Frequent nausea or vomiting	____	____
Fever or night sweats	____	____	Recent unexplained weight loss	____	____
Are you pregnant	____	____	Frequent or sever abdominal pain	____	____
Loss of appetite	____	____	Shortness of breath	____	____
Dizziness	____	____			

Are you currently taking medications? ____Yes ____No Names or Types: ___________________________

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Other medical history: ____

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