

PATIENT HISTORY

NAME: _____ DATE OF NEXT MD APPOINTMENT: _____

Describe briefly the history of your present ACCIDENT, INJURY, ILLNESS OR CONDITION:

Onset Date: _____ Description: _____

Please list any special concerns, questions or expectations: _____

Have you fallen in the past year? _____ If so, how many times? _____ If so, did you sustain an injury? _____

Have you had any physical therapy during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? _____ If yes, please indicate where and when:

List **ALL** medications you are currently taking: _____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.? Describe _____

Please list **ALL** surgeries you have had; please give procedures and dates, if possible: _____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Tobacco use	Yes	No
Diabetes	Yes	No			

SIGNATURE: _____ DATE: _____