



**PHYSICAL THERAPY & FITNESS**

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**MEDICAL HISTORY FORM**

Please complete the following. If you do not understand a question, please ask your therapist to assist you.

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender: M F

Do you have a pacemaker? Yes No Are you pregnant? Yes No

Occupation: \_\_\_\_\_ Presently working: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Not Employed \_\_\_\_\_

Physical Activities at Work: \_\_\_\_\_

General Health: Excellent \_\_ Good \_\_ Average \_\_ Fair \_\_ Poor \_\_

Date of Last Physical Exam: \_\_\_\_\_ Exercise Level: None\_\_ 1-2x's/wk\_\_ 3-4x's/wk\_\_ 5+x's/wk\_\_

Type of Exercise: \_\_\_\_\_

Do you experience any symptoms during heavy exercise? Y N

If yes please explain: \_\_\_\_\_

Stress Level: Low\_\_ Medium\_\_ High\_\_

Hobbies: \_\_\_\_\_

Are you currently seeing any of the following?

Medical Doctor Yes No Psychiatrist/Psychologist Yes No Chiropractor Yes No Dentist Yes No Physical Therapist Yes No

If you have seen any of the above in the last 3 months, please describe for what reason (illness, medical condition, physical exam, etc.): \_\_\_\_\_

**In the past 6 months, have you had?**

Difficulty with bowel/bladder control	Y	N	Fever/Chills	Y	N	Numbness	Y	N	Numbness in the genital/anal area	Y	N
Night/Pain Sweats	Y	N	Weakness	Y	N	Chest Pains	Y	N	Vision/Hearing Problems	Y	N
Unexplained weight gain	Y	N	Leg Swelling	Y	N	Dizziness	Y	N	Bodily Discomfort	Y	N
Shortness of Breath	Y	N	Fainting	Y	N	Other:				Y	N

**Have you ever been diagnosed as having any of the following?**

Emphysema/Bronchitis	Y	N	Asthma	Y	N	Kidney Disease	Y	N	High Blood Pressure	Y	N
Thyroid Problems	Y	N	Diabetes	Y	N	Hepatitis	Y	N	Rheumatoid Arthritis	Y	N
Tuberculosis	Y	N	Depression	Y	N	Epilepsy/Seizures	Y	N	Other Arthritic condition	Y	N
Anemia	Y	N	Stroke	Y	N	Heart Problem	Y	N	Parkinson's Disease	Y	N
Multiple Sclerosis	Y	N	Allergies	Y	N	Cancer	Y	N	Chemical Dependency/Alcoholism	Y	N

If you marked yes for Cancer what kind? \_\_\_\_\_

**Do you have any of the following risk factors for Heart Disease?**

High Blood Pressure Yes No Diabetes Yes No High Cholesterol Yes No Smoking Yes No  
 Heart Disease Yes No Family History of Heart Disease Yes No

Amount of Alcohol Consumption (# of Drinks) per Week \_\_\_\_\_ Number of Cigarettes/Cigars per Week \_\_\_\_\_

**Does any injury or condition significantly impact your function in these areas?**

Work YES NO Food/Meals YES NO Safety YES NO Personal Care YES NO Mobility at Home YES NO  
 Transportation YES NO Finances YES NO Emotional Stability, including withdrawal or depression YES NO

**Do you have adequate support at home – physical and emotional – to meet the challenges of your condition?** YES NO

Please list any surgeries or conditions for which you have been hospitalized which may pertain to your condition.

<u>Date</u>	<u>Surgery/Hospitalization</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications including prescriptions, herbal remedies, and over the counter, in any form (pills, injections, skin patches) are you currently taking?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Form reviewed with patient? Yes No \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_