THE PHYSICAL THERAPY INSTITUTE
ORTHOPEDICS AND SPORTS MEDICINE

PAST MEDICAL HISTORY FORM

NAME: _____ **AGE:** _____ **GENDER: M F**

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

PAST MEDICAL HISTORY (Check all that apply)

_____ HEART ATTACK _____ NECK/BACK PAIN _____ CANCER ____ HEADACHES

_____ STENT _____ SHOULDER PAIN _____ ULCERS ____ DEPRESSION

_____ TRANSPLANT _____ ELBOW/WRIST/HAND PAIN _____ ARTHRITIS ____ OSTEOPOROSIS

_____ ANGINA/CHEST PAIN _____ FOOT/ANKLE PAIN _____ DIZZINESS ____ FAINTING

_____ CONGESTIVE HEART FAILURE _____ DIABETES _____ HIGH BLOOD PRESSURE ____ SWELLING

_____ PERIPHERAL VASCULAR DISEASE _____ ASTHMA _____ APPETITE CHANGES

_____ KNEE PAIN _____ STROKE _____ **PACEMAKER**

_____ PRIOR SURGERIES (LIST ALL): _____

_____ ALLERGIES (LIST ALL): _____

IN THE PAST THREE MONTHS, HAVE YOU HAD OR DO YOU EXPERIENCE:

_____ NAUSEA/VOMITING _____ FEVER/CHILLS/SWEATS _____ NUMBNESS/TINGLING

_____ APPETITE CHANGES _____ UNEXPLAINED WEIGHT CHANGE _____ SHORTNESS OF BREATH

_____ DIFFICULTY SWALLOWING _____ BOWEL/BLADDER CHANGES _____ FEVER

_____ DIFFICULTY SLEEPING/NIGHT PAIN _____ BRONCHITIS _____ KIDNEY DISEASE

I CURRENTLY HAVE DIFFICULTY (Check all that apply)

_____ DRIVING _____ WALKING _____ SITTING

_____ BENDING/LIFTING _____ STANDING _____ VISION

_____ GETTING UP FROM A CHAIR _____ HEARING _____ SPEECH

Are you currently feeling content with your life? **___ Yes** **___ No**

Are you currently seeking counseling or have you in the past? **___ Yes** **___ No**

Are you interested in talking to someone in your current situation? **___ Yes** **___ No**

Are there any issues in your life that you need help? **___ Yes** **___ No**

Is there a history of mental health or substance abuse in your family? **___ Yes** **___ No**

PATIENT SIGNATURE: _____ **DATE:** _____

Prepared by (If Not Patient) _____ **DATE:** _____

THERAPIST SIGNATURE: _____ **DATE:** _____