PREVIOUS MEDICAL HISTORY

PATIENT NAME: _____

DOB: _____

EXISTING / PREVIOUS CONDITIONS

Allergies	OYes ONo	Diabetes	OYes ONo	Metal Implants	OYes ONo
Anemia	OYes ONo	Dizzy Spells	OYes ONo	MRSA	OYes ONo
Anxiety	OYes ONo	Emphysema/Bronchitis	OYes ONo	Multiple Sclerosis	OYes ONo
Arthritis	OYes ONo	Fibromyalgia	OYes ONo	Muscular Disease	OYes ONo
Asthma	OYes ONo	Fractures	OYes ONo	Osteoporosis	OYes ONo
Autoimmune Disorder	OYes ONo	Gallbladder Problems	OYes ONo	Parkinson's	OYes ONo
Cancer	OYes ONo	Headaches	OYes ONo	Rheumatoid Arthritis	OYes ONo
Cardiac Conditions	OYes ONo	Hearing Impairment	OYes ONo	Seizures	OYes ONo
Cardiac Pacemaker	OYes ONo	Hepatitis	OYes ONo	Smoking	OYes ONo
Chemical Dependency	OYes ONo	High Cholesterol	OYes ONo	Speech Problems	OYes ONo
Circulation Problems	OYes ONo	High/Low Blood Pressure	OYes ONo	Strokes	OYes ONo
Currently Pregnant	OYes ONo	HIV/Aids	OYes ONo	Thyroid Disease	OYes ONo
Depression	OYes ONo	Incontinence	OYes ONo	Tuberculosis	OYes ONo
		Kidney problems	OYes ONo	Vision Problems	OYes ONo

Describe any other conditions or precautions or give details for positive answers above:

Visual Analog Scale Circle **LOW** and **HIGH** Pain Level**s**

0 1 2 3 4 5 6 7 8 9 10

PAIN FREE **MODERATE** **SEVERE**

Height: _____ **Weight:** _____	**FALL HISTORY:** ❑ YES ❑ NO Is this injury a result of a fall in the past year? ❑ YES ❑ NO Have you had TWO or more falls in this past year?
Surgical History / DATE	
Medications LIST	

_____

Patient Signature Date Physical Therapist Date