Performance Physical Therapy
Care at its Best!
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PAST MEDICAL HISTORY

PATIENT NAME:_____
LAST FIRST INITIAL DOB

Please circle all that apply.

1.Please list any medications & dosage you are taking:_____

_____

_____

2. Are you allergic to any medications or substances? ……..	yes	no
3. Are you sensitive/allergic to latex and or tape? ……	yes	no
4.Do you have a pacemaker? ……	yes	no
5.Do you or have you had high/low blood pressure? ……..	yes	no
6.Do you have a history of angina or other health problems? ……	yes	no
7.Do you have any respiratory problems?(asthma,emphysema,etc.) ……..	yes	no
8.Do you have a history of cancer? ……	yes	no
9.Do you have diabetes? ……	yes	no
10.Do you have any artificial joints or prosthesis? …….	yes	no
11.Do you have any arthritis or any unusual joint swelling? …….	yes	no
12.Do you have osteoperosis? ……..	yes	no
13.Do you have epilepsy or seizure disorders? ……	yes	no
14.Have you had a stroke, head injury or concusion? …….	yes	no
15.Have you been diagnosed with fibromyalgia, chronic fatigue syndrome, or fibromyositis? ……..	yes	no
16.Have you been diagnosed with any muscular diseases? ……. (multiple sclerosis, polio, carebral palsy, etc.)	yes	no
17.Have you tested positive for HIV/AIDS? ……..	yes	no
18.Have you had or do you test positive for hepititis? …….	yes	no
19.Do you have night sweats, fevers, or chills? ……	yes	no
20.Have you had any unexplained weight loss or gain? …….	yes	no
21.Have you experienced any loss of balance or falling? …….	yes	no
22.Do you have any hearing loss? ……..	yes	no
23.Do you consume any alcoholic beverages? _____/per week	yes	no
24.Do you smoke? _____/per day ……	yes	no
25.Do you exercise regularly? _____/per wk ……	yes	no
26.Have you ever had home care services? (nursing, PT, OT, etc.) ……	yes	no
27.Have you had any other Physical or Speech therapy this year? ……..	yes	no
28.Have you had any major surgeries?_____ _____	yes	no
29.**Do you have any disease, condition or problem not listed?** ……	yes	no

If so, please explain._____

_____

COMMENTS

WOMEN ONLY

30.Are you or could you be pregnant? ……	yes	no
31.Have you had a hysterectomy? ……..	yes	no

other surgeries?_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient/Guardian Signature:_____ Date:_____

Therapist:_____ Date:_____