Health Plus
PHYSICAL THERAPY CENTER

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

Date of Injury: _____ Date of next doctor's visit for this injury: _____

Have you had surgery for this injury: ___Yes ____No Date of surgery: _____

Are you currently taking any prescription or non-prescription medications? : ____Yes ___ No

Please list all medications you are currently taking, please include dosage:

_____

	YES	NO			YES	NO
Asthma, Bronchitis or Emphysema				Severe or frequent headaches		
Shortness of breath/Chest pain				Vision or hearing difficulties		
Coronary Artery Disease or Angina				Numbness or tingling		
Do you have a pacemaker?				Dizziness or fainting		
High blood pressure				Bowel or bladder problems		
Heart attack or surgery				Weakness		
Stroke/TIA				Weight loss/Energy loss		
Congestive Heart Disease				Hernia		
Blood clot/Emboli				Varicose Veins		
Epilepsy/Seizures				Allergies		
Thyroid Disease or Goiter				Any pins or metal implants		
Anemia				Joint replacement surgery		
Infectious diseases				Neck injury or surgery		
Diabetes				Shoulder injury or surgery		
Cancer or chemotherapy				Elbow injury or surgery		
Arthritis				Back injury or surgery		
Osteoporosis				Are you pregnant?		
Gout				Do you use tobacco?		
Sleeping problems/Difficulties				If yes, how long have you used tobacco?		
Emotional/Psychological problems				How often do you use tobacco?		

List any other information that would assist us in your care: _____

_____

What are your rehabilitation expectations/ goals while in this program? _____

_____

Patient/ Guardian Signature: _____ Date: _____

: