MEDICAL HISTORY

Patient Name: ____

Please circle correct response and explain below if yes:

Blood Pressure Problems	Yes	No	Diabetes	Yes	No
Cardiac Disease	Yes	No	GI Symptoms	Yes	No
Seizures	Yes	No	Strokes	Yes	No
Dizziness	Yes	No	Pulmonary Dx.	Yes	No
Liver Disease	Yes	No	Kidney Dx.	Yes	No
Cancer	Yes	No	Infectious Dx.	Yes	No
Hernia	Yes	No	Depression	Yes	No
Fractures	Yes	No	Arthritis	Yes	No
Pregnancy	Yes	No	Trauma/Injury	Yes	No
Drug Allergies	Yes	No	Other	Yes	No

Explanations for any of the above: ____

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Medications: Please list any medications you are currently taking: ____________________

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Past Surgical History: Please list any surgeries you have had and when: ________________

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Special Tests: Please list any tests you have had along with where and when, ie. X-rays, CT scan, EMG, MRI, etc. ____

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Comments or Concerns:____

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Patient Signature

Physical Therapist's comments, if applicable:____

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Physical Therapist's Signature