Medical History and Systems Review

Please provide us with you medical history and pertinent background information. This information will assist your physical therapist in providing a complete and thorough evaluation.

Date: ________________________

Name: ________________________________ Age: ____________________ Gender: F / M

Occupation: ___________________________ Leisure Activities: ____

Describe your reason for today's visit: ____

____

Date of Injury/Onset of Problem: ________________________

Was the onset (place a check): Gradual _____ Sudden _____

How did the problem occur? ____

Have you had any previous or similar problems? YES NO
If yes, please explain:

____

____

Please place a check mark if you are under the care of any of the following:

_____Medical Doctor (MD) _____Physical Therapist _____Psychiatrist/Psychologist
_____Doctor of Osteopathy (DO) _____Chiropractor Other ____________________

If you have seen any of the above during the past three months, please desribe the reason (illness, medical condition, physical exam):

____

____

Please list previous surgeries or any other conditions for which you have been hospitalized:

Date (approximate) Surgery/Reason for Hospitalization

______________ ____

______________ ____

______________ ____

Please describe any injuries for which you have been treated:

Date (approximate) Injury

______________ ____

______________ ____

______________ ____

Have you taken any OVER-THE-COUNTER medication in the past 2 weeks?

YES NO Advil/Motrin/Ibuprophen
YES NO Antihistamines
YES NO Aspirin
YES NO Decongestants
YES NO Tylenol
YES NO Vitamins/Mineral Supplements
YES NO Other___________________

Please list any PRESCRIPTION medication that you are currently taking (including pills, injections, and skin patches):

1. _______________ 2. _______________ 3. _______________ 4. _______________

Are you ALLERGIC to Latex? YES NO Please list any other ALLERGIES:

1. _______________ 2. _______________ 3. _______________ 4. _______________

Have you EVER been diagnosed as having any of the following conditions?

YES NO Anemia
YES NO Asthma
YES NO Cancer If YES, what kind? ____
YES NO Chemical Dependency (e.g. alcoholism)
YES NO Circulation Problems
YES NO Depression
YES NO Diabetes
YES NO Emphysema
YES NO Epilepsy
YES NO Heart Problems If YES, describe ____
YES NO Hepatitis
YES NO High Blood Pressure
YES NO Kidney Disease
YES NO Multiple Sclerosis (MS)
YES NO Rheumatoid Arthritis
YES NO Other arthritic conditions ____
YES NO Stroke
YES NO Thyroid Problems If YES, describe ____
YES NO Tuberculosis
YES NO Other ____

DURING THE PAST MONTH:

Have you been feeling down, depressed, or hopeless? YES NO
Have you been bothered by having little interest or pleasure in doing things? YES NO

FOR WOMEN:

Are you currently pregnant or think that you might be pregnant? YES NO
Are you taking any fertility drugs? YES NO

How much coffee or other caffeinated beverages do you drink per day? _______________

How many packs of cigarettes do you smoke per day? _______________

How many days per week do you drink alcohol? _______________

Have you recently experienced:

YES NO Fever/Chills/Sweats YES NO Dizziness/Lightheadedness
YES NO Unexplained weight loss/gain YES NO Weakness
YES NO Fatigue YES NO Numbness or Tingling
YES NO Nausea/Vomiting If YES, describe ____
YES NO Difficulty Urinating YES NO Shortness of Breath
YES NO Changes in Frequency of Urination
If YES, explain _____________________________________