# MEDICAL HISTORY

**Date:** ____________________

**Name:** ____________________________________________________

**Date of Birth:** _________/_________/_________

**Sex:** ☐ Male ☐ Female

**Are you:** ☐ Right-handed ☐ Left-handed

**Race**
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black ☐ White

**Ethnicity**
☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Education**
☐ Highest grade completed (circle one): 1 2 3 4 5 6 7 8 9 10 11 12
☐ Some college / technical school
☐ College graduate
☐ Graduate school / advanced degree

**SOCIAL HISTORY**
**Cultural / Religious**
Any customs or religious beliefs or wishes that might affect care?
____________________________________________________________

**With whom do you live?**
☐ Alone
☐ Spouse only
☐ Spouse and other(s)
☐ Child (not spouse)
☐ Other relative(s) (not spouse or children)
☐ Group setting
☐ Personal care attendant
☐ Other: ________________________________________________

**13. Employment / Work (Job / School / Play)**
☐ Working full-time outside of home ☐ Working part-time outside of home
☐ Working full-time from home ☐ Working part-time from home
☐ Homemaker ☐ Student ☐ Retired ☐ Unemployed
Occupation: ____________________________________________

**LIVING ENVIRONMENT**

**Does your home have:**
☐ Stairs, no railing
☐ Stairs, railing
☐ Ramps
☐ Elevator
☐ Uneven terrain
☐ Assistive devices (eg, bathroom): ____________________

**Do you use:**
☐ Cane
☐ Walker or rollator
☐ Manual wheelchair
☐ Motorized wheelchair
☐ Glasses, hearing aids
☐ Other: ________________ ________________

☐ Any obstacles: ______________

**Where do you live?**
☐ Private home
☐ Private apartment
☐ Rented room
☐ Board and care / assisted living / group home
☐ Homeless (with or without shelter)

**Where do you live?** *continued*
☐ Nursing home
☐ Hospice
☐ Other: ______________________________________________

**GENERAL HEALTH STATUS**
**A.** Please rate your health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

**B.** Have you had any major life changes during the past year? (eg, new baby, job change, death of a family member)
☐ Yes ☐ No

**SOCIAL / HEALTH HABITS**
**A. Smoking**
Currently smoke tobacco?
☐ Yes
1. ☐ Cigarettes # of packs per day ______
2. ☐ Cigars/Pipes # per day ______
☐ No

Smoked in past?
☐ Yes
Year quit: ___ ___ ___ ___
☐ No

**B. Alcohol**
How many days per week do you drink beer, wine or other alcoholic beverages, on average? ________

If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? ________

**C. Exercise**
Do you exercise beyond normal daily activities and chores?
☐ Yes
Describe the exercise: ______________________________
1. On average, how many days per week do you exercise or do physical activity? __________
2. For how many minutes, on an average day? ________
☐ No

**D. Hobbies** ____________________________________________

**FAMILY HISTORY**
( Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)
Heart disease: ________________________________________
Hypertension: ________________________________________
Stroke: _____________________________________________
Diabetes: ___________________________________________
Cancer: _____________________________________________
Psychological: ________________________________________
Arthritis: ___________________________________________
Osteoporosis: ________________________________________
Other: ______________________________________________

*continued on other side*

**MEDICAL HISTORY, cont.**

## MEDICAL/SURGICAL HISTORY

**A.** Please check if you have ever had:

- ☐ Arthritis
- ☐ Broken bones/fractures
- ☐ Osteoporosis
- ☐ Blood disorders
- ☐ Circulation/vascular problems
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Stroke
- ☐ Diabetes/high blood sugar
- ☐ Low blood sugar/hypoglacemia
- ☐ Head injury
- ☐ Multiple sclerosis
- ☐ Muscular distrophy
- ☐ Parkinson's disease
- ☐ Seizures/epilepsy
- ☐ Allergies
- ☐ Developmental or growth problems
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Infectious disease (eg, tuberculosis, hepatitis)
- ☐ Kidney problems
- ☐ Repeated infections
- ☐ Ulcers/stomach problems
- ☐ Skin diseases
- ☐ Depression
- ☐ Other: ____________________

**B.** Within the past year have you had any of the following symptoms? (Check all that apply.)

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarsneness
- ☐ Shortness of breath
- ☐ Dizzines or blackouts
- ☐ Coordination problems
- ☐ Weakness in arms or legs
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Joint pain or swelling
- ☐ Pain at night
- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Nausea / vomiting
- ☐ Difficulty swallowing
- ☐ Bowel problems
- ☐ Weight loss / gain
- ☐ Urinary problems
- ☐ Fever / chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Other: ____________________

**C.** Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe, and include dates:

____________________ Month __ __ Year __ __ __ __

____________________ Month __ __ Year __ __ __ __

____________________ Month __ __ Year __ __ __ __

**For men only:**

Have you been diagnosed with prostate disease?

☐ Yes ☐ No

**For women only:**

| | | |
|---|---|---|
| Pelvic inflamatory disease? | ☐ Yes | ☐ No |
| Endometriosis? | ☐ Yes | ☐ No |
| Trouble with your period? | ☐ Yes | ☐ No |
| Complicated pregnancies or deliveries? | ☐ Yes | ☐ No |
| Pregnant, or think you might be pregnant? | ☐ Yes | ☐ No |
| Other gynecological or obstetrical difficulties? | ☐ Yes | ☐ No |

If yes, please describe: ____________________

## CURRENT CONDITIONS(S) CHIEF COMPLAINT(S)

**A.** Describe the problem(s) for which you seek physical therapy

____________________

____________________

**B.** When did the problem(s) begin (date)? Month __ __ Year __ __ __ __

**C.** What happened? ____________________

____________________

____________________

**D.** Have you ever had the problem(s) before?

☐ Yes

What did you do for the problem(s)? ____________________

Did the problem(s) get better? ☐ Yes ☐ No

About how long did the problem(s) last? ____________________

☐ No

**E.** How are you taking care of the problem(s) now? ____________________

**F.** What makes the problem(s) better? ____________________

**G.** What makes the problem(s) worse? ____________________

**H.** What are your goals for physical therapy? ____________________

**I.** Are you seeing anyone else for the problem(s)? (Check all that apply.)

- ☐ Acupuncturist
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Family practitioner
- ☐ Internist
- ☐ Massage therapist
- ☐ Neurologist
- ☐ Obstetrician/gynecologist
- ☐ Occupational therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Poditrist
- ☐ Primary care physician
- ☐ Rheumatologist
- Other: ____________________

## FUNCTIONAL STATUS / ACTIVITY LEVEL (Check all that apply.)

- ☐ Difficulty with locomotion/movement:
  - ☐ bed mobility
  - ☐ transfers (such as moving from bed to chair, from bed to commode)
  - ☐ gait (walking)
    - ☐ on level
    - ☐ on ramps
    - ☐ on stairs
    - ☐ on uneven terrain
- ☐ Difficulty with self-care (such as bathings, dressing, eating, toileting)
- ☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
- ☐ Difficulty with community and work activities/integration
  - ☐ work / school
  - ☐ recreation or play activity

## MEDICATIONS

**A.** Do you take any prescription medications? ☐ Yes ☐ No

If yes, please list: ____________________

____________________

**B.** Do you take any nonprescription medications? (Check all that apply.)

- ☐ Advil/Aleve
- ☐ Antacids
- ☐ Ibuprofen/Naproxen
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Decongestants
- ☐ Herbal supplements
- ☐ Tylenol
- Other: ____________________

____________________

**c.** Have you taken any medications previously for the condition for which you are seeing the physical therapist?

☐ Yes ☐ No If yes, please list: ____________________

____________________

## OTHER CLINICAL TESTS—Whithin the past year, have you had any of the following tests? (Check all that apply.)

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ Bronchoscopy
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG (electroencephalogram)
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (nerve conduction velocity)
- ☐ Pap smear
- ☐ Pulmonary function test
- ☐ Spinal tab
- ☐ Stool tests
- ☐ Stress test (eg, treadmill, bicycle)
- ☐ Urine tests
- ☐ X-rays
- ☐ Other: ____________________