DECATUR PHYSICAL THERAPY & SPORTS MEDICINE
Patient Medical History

Patient: _____Age: _____ Date: _____

GENERAL HEALTH INFORMATION: Tell us about your health other than this injury/problem.

Please describe any other orthopaedic or musculoskeletal injuries/problems:

_____

_____

List any other past surgeries or hospitalizations and dates:

_____

_____

Are there any other medical conditions that your physical therapist should know about?

_____

_____

Do you have any metal implants (plates, screws, staples)? ❑ YES ❑ NO

Have you had any lab work recently? ❑ YES ❑ NO
Please explain when/where and results _____

_____

Please list all medications you are taking NOW (include prescriptions, over-the-counter medicines, vitamins, herbs and natural/homeopathic medicines, with the dose/frequency.)

_____

_____

_____

_____

_____

Have you ever been diagnosed or treated for any of the following?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension/High Blood Pressure
- ❑ Heart Disease
- ❑ Angina/Chest pain
- ❑ Shortness of breath/Asthma
- ❑ Stroke
- ❑ Kidney Disease/Infection
- ❑ Insomnia
- ❑ Osteoporosis
- ❑ Hepatitis/Liver Disease
- ❑ Emphysema
- ❑ Migraine Headaches
- ❑ Ulcers/Stomach Problems
- ❑ Allergies
- ❑ Depression
- ❑ Recent Weight Loss/Gain
- ❑ Epilepsy/Convulsions
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Rheumatoid Arthritis
- ❑ Chills/Night Sweats

Do you have a pacemaker and/or a defibrillator? ❑ YES ❑ NO

Do you smoke cigarettes, a pipe or chew tobacco? ❑ YES ❑ NO

Have you had Physical Therapy before for other problems?

If yes, where/when? _____

FOR WOMEN ONLY:

Are you pregnant?	❑ YES	❑ NO
Are you planning to become pregnant in the immediate future?	❑ YES	❑ NO
How many pregnancies have you had? _____		
Are you menopausal?	❑ YES	❑ NO
Are you taking estrogen/hormone replacement therapy?	❑ YES	❑ NO

When do you return to see your physician? _____

Person completing form _____ Date _____

Reviewed by: _____ Date _____