RESTORATION PHYSICAL THERAPY

# *PAST MEDICAL HISTORY FORM*

Patient Name: _____ DOB: _____

Name of Referring Physician:_____ Primary Care MD:_____

**Date of next physician's visit:** _____

Occupation: _____

Are you presently working? ☐ Yes ☐ No Light Duty? ☐ Yes ☐ No
Physician's Restrictions:_____

Date of Injury/Onset:_____
Date of Surgery:_____

Please describe your
Condition:_____
_____

Check which apply to your symptoms:

| | |
|---|---|
| ☐ work related injury | ☐ Injury related to lifting |
| ☐ motor vehicle accident | ☐ Injury related to falling |
| ☐ Athletic /Rec. Injury | ☐ cause unknown |

Medical History

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Allergies | ☐ | ☐ | Dizzy Spells | ☐ | ☐ | MRSA | ☐ | ☐ |
| Anemia | ☐ | ☐ | Emphysema/Bronchitis | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ |
| Anxiety | ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Muscular Disease | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Gallbladder Problems | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Fractures | ☐ | ☐ | Parkinson's | ☐ | ☐ |
| Autoimmune Disorder | ☐ | ☐ | Headaches | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ |
| Cancer | ☐ | ☐ | Hearing Impaired | ☐ | ☐ | Seizures | ☐ | ☐ |
| Cardiac Conditions | ☐ | ☐ | Hepatitis | ☐ | ☐ | Smoking | ☐ | ☐ |
| Cardiac Pacemaker | ☐ | ☐ | High Cholesterol | ☐ | ☐ | Speech Problems | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Strokes | ☐ | ☐ |
| Circulation Problems | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Currently Pregnant | ☐ | ☐ | Incontinence | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Depression | ☐ | ☐ | Kidney Problems | ☐ | ☐ | Vision Problems | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Metal Implants | ☐ | ☐ | | | |

**Describe any other condition or precautions:**

**Fall History**

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of Fall: _____
Two or more falls in the last year? ☐ Yes ☐ No Date of Falls: _____

RESTORATION
PHYSICAL THERAPY

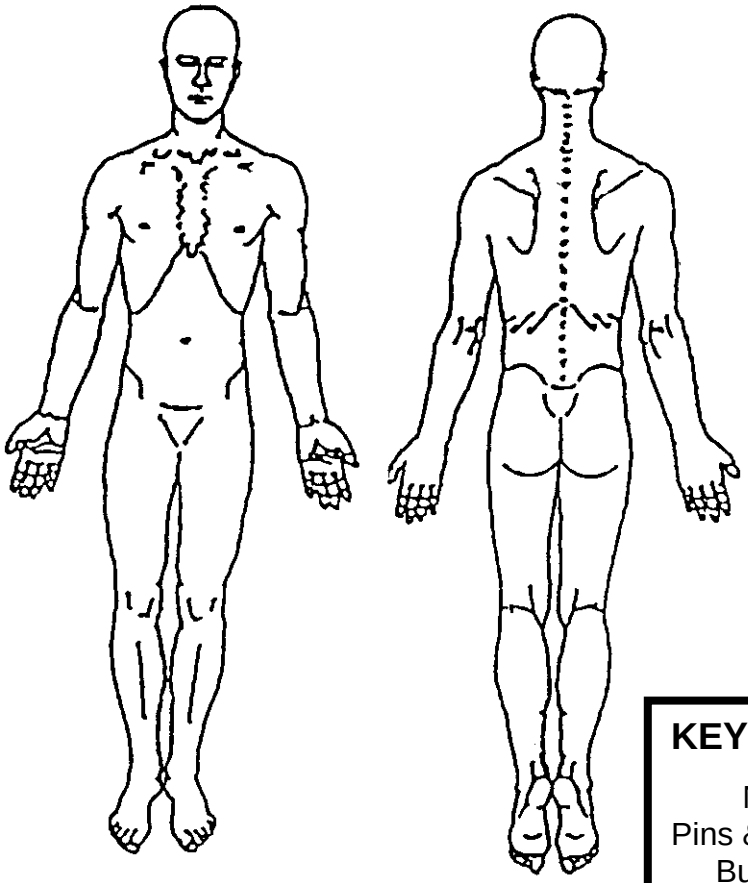
**Surgical History**

Body Region: _____ Surgery Type: _____ Date of Surgery: _____
Body Region: _____ Surgery Type: _____ Date of Surgery: _____
Body Region: _____ Surgery Type: _____ Date of Surgery: _____
Body Region: _____ Surgery Type: _____ Date of Surgery: _____
Body Region: _____ Surgery Type: _____ Date of Surgery: _____

**Current Medications**

Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____
Drug: _____ Dosage: _____ Reason for Taking: _____

Please indicate below where your symptoms are located:



Pain Level at Worse
( 0 = no pain 10 = emergency room) _____

Pain Level at Best
( 0 = no pain 10 = emergency room) _____

Activities that make your pain worse:

_____
_____
_____
_____

**KEY:**

| | |
|---|---|
| Numbness | = = = = = |
| Pins & Needles | ooooooo |
| Burning Pain | xxxxxxxx |
| Stabbing Pain | / / / / / / / |