UNIVERSITY PHYSICAL THERAPY MEDICAL HISTORY FORM

Name_____ Daytime phone #_____
Occupation:_____
Emergency Contact (name and phone number)_____

- Name of primary physician_____
- Name of referring physician_____
- When are you scheduled to return to your referring physician?_____
- Have you seen anyone else for your current condition?

☐ Physician/MD ☐Chiropractor ☐Podiatrist ☐Orthopedic Surgeon
☐Dentist ☐Neurologist ☐Physical Therapist ☐Other (specify: _____)

Past Medical History:
Have you ever had any of the following conditions? Check all that apply.

☐High blood pressure ☐Heart condition ☐Stroke ☐Osteoporosis
☐Peripheral Neuropathy ☐Seizures/epilepsy ☐Vision problems ☐Diabetes
☐Hearing problems ☐Fainting/dizziness ☐Emphysema ☐Frequent or severe headaches
☐Bowel/bladder problems ☐Cancer ☐Arthritis ☐Asthma
☐Other:_____

Have you had any falls in the past year? YES NO If so, about how many? _____
Do you have a history of fractures? YES NO Where?_____
Do you have any metal implants? YES NO Where?_____
Do you smoke? YES NO How much per day?_____
Do you exercise regularly? YES NO How often?_____
Do you have any known allergies? YES NO Please list_____
Are you pregnant or think that you might be? YES NO

Medications:
Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking:
_____
_____

Surgeries: Please list all surgeries including dates:_____
_____

Diagnostic Tests: Please check any tests or procedures that have been done for your **current** condition.

☐X-rays ☐MRI ☐CT scan ☐Bone scan
☐EMG ☐Blood work ☐Bone density ☐Ultrasound

Current Condition

- What is the problem you are here for?_____
  _____
- What is the date when the problem started? _____
- Have you had similar symptoms before?_____
- Have you had previous treatment for this condition?_____

Patient Signature_____ Date_____

Therapist Signature_____ Date_____