ADVANCED ORTHOPAEDIC
Physical Therapy PSC

Patient Medical History

Patient Name: _____ Date: _____

Telephone#: _____ Referring Physician: _____

MEDICAL INFORMATION:

To the best of your knowledge, do you have or have had:

1. High Blood Pressure	yes	no	25. Thyroid Problems	yes	no
2. Chest Pains/Angina /Heart	yes	no	26. Polio/Muscle Disease	yes	no
3. High Cholesterol	yes	no	27. Seizures	yes	no
4. Pacemaker	yes	no	28. Chronic/Migraine	yes	no
5. Shortness of Breath	yes	no	29. TMJ Disorders	yes	no
6. History of Smoking	yes	no	30. Chills/Fevers Sweats	yes	no
7. Lung Problems	yes	no	31. Swelling of Extremities	yes	no
8. Emphysema/Asthma	yes	no	32. Osteoporosis	yes	no
9. Bleeding/Bruising	yes	no	33. Depression	yes	no
10. Anemia	yes	no	34. Fibromyalgia	yes	no
11 Diabetes	yes	no	35. Chronic Fatigue Syndrome	yes	no
12. Hypoglycemia	yes	no	36. Lyme's Disease	yes	no
13. Lightheadedness/Dizziness	yes	no	37. Cancer/Tumors/Growths	yes	no
14. Blood Disorders	yes	no	38. Are you pregnant?	yes	no
15. Concussion	yes	no	39. Gynecological Disorders	yes	no
16. Fainting Disorders	yes	no	40. Bladder Incontinence	yes	no
17. Anxiety/Panic Attacks	yes	no	41. Bowel Incontinence	yes	no
18. Arthritis/Joint Pain	yes	no	42. Diarrhea/Nausea/Vomiting	yes	no
19. Artificial Joints	yes	no	43. Unexplained Weight Loss	yes	no
20. Kidney Disease/Stones	yes	no	**UNDER 18 ONLY**:		
21. Hepatitis	yes	no	44. Immunizations Current	yes	no
22. Spinal Cord Injury	yes	no			
23. Traumatic Brain Injury	yes	no			

24. Fractures:

Date: Area:

Date: Area:

Patient Medical History

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Patient Name: _____

Do you have a history of back/neck pain?

How/when did the pain occur? _____

Do you have any metal implants?

If so, where? _____

Do you smoke?

How much per day? _____

Do you exercise regularly?

How often? _____

Do you have any known drug allergies?

Please list: _____

Are you pregnant or suspect pregnancy? _____

In regard to your current condition:

(Please rate your pain) 0 1 2 3 4 5 6 7 8 9 10

no pain ***worst pain***

Do you have any "pins and needles" or numbness in your extremities? Yes ( ) No ( )

Do you have any weakness in your arms or legs? Yes ( ) No ( )

Do you have any coordination or balance problems? Yes ( ) No ( )

Do you have difficulty walking? Yes ( ) No ( )

Do you experience dizziness or vertigo with a change in position? Yes ( ) No ( )

Have you experienced headaches as a result of your condition? Yes ( ) No ( )

Were you injured in a work related incident? Yes ( ) No ( )

Please list all current medications:

_____

Please list all surgeries/dates: (use back of page if necessary):

_____

Please check recent diagnostic tests performed:

X-Ray ( ) MRI ( ) CT Scan ( ) Bone Scan ( ) Bone Density ( ) EMG ( ) Ultrasound ( )

Patient Medical History

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Patient Name:

_____

Please describe your chief complaint and current condition:

_____

_____

_____

_____

I believe all information to be true and complete:

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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