Mid-County Physical Therapy

Outpatient Medical History

Name: _____ **Date:** _____

Referring Physician: _____ **Family Physician:** _____

Do you have or have you ever had any of the following?

	Yes	No
Asthma, Bronchitis, Emphysema	___	___
Shortness of Breath/ Chest Pain	___	___
Coronary Artery Disease / Angina	___	___
Pacemaker	___	___
High Blood Pressure	___	___
Heart Attack / Heart Surgery	___	___
Stroke / TIA	___	___
Congestive Heart Failure	___	___
Blood Clot / Emboli	___	___
Epilepsy / Seizures	___	___
Thyroid Disease	___	___
Anemia	___	___
Infectious Disease	___	___
Diabetes	___	___
Cancer / Chemotherapy / Radiation	___	___
Arthritis	___	___
Osteoporosis	___	___
Gout	___	___
Sleeping Problems / Difficulties	___	___
Emotional / Psychological Problems	___	___
Cortisone Shot / Epidural	___	___

	Yes	No
Severe or Frequent Headaches	___	___
Vision or Hearing Difficulties	___	___
Numbness or Tingling	___	___
Dizziness or Fainting	___	___
Weakness	___	___
Weight Loss / Energy Loss	___	___
Bowel or Bladder Problems	___	___
Hernia	___	___
Varicose Veins	___	___
Allergies (including Drug)	___	___
Any Pins or Metal Implants	___	___
Joint Replacement Surgery	___	___
Neck Injury / Surgery	___	___
Shoulder Injury / Surgery	___	___
Elbow / Wrist or Hand Injury / Surgery	___	___
Back Injury / Surgery	___	___
Knee Injury / Surgery	___	___
Leg / Ankle or Foot Injury / Surgery	___	___
Are you Pregnant ?	___	___
Do you use Tobacco?	___	___
Other: _____	___	___

If you answered **YES** to any questions above, please explain:

_____

_____

FALL RISK ASSESSMENT

	YES	NO
Are you seeing a physician for dizziness or imbalance?	____	____
Do you have loss of balance or require assistance when getting up from sitting?	____	____
Do you have difficulty walking without holding onto furniture or walls?	____	____
Do you use an assistive device for walking (i.e. cane, walker, wheelchair)?	____	____
If yes, please list: _____		
How many times have you fallen in the last 3 months?	____	____
When and how did you last fall? _____		

MEDICATION LIST

Please list **ANY / ALL** medications that you are currently taking. Including prescribed, over the counter or vitamins, etc.
PLEASE INFORM US IF YOU BEGIN TAKING ANY NEW MEDICINE(S) DURING YOUR COURSE OF TREATMENT.

____ I am currently ***NOT*** taking any prescribed medication, over the counter, or vitamins, etc.

NAME	DOSAGE	FREQUENCY

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