BELLE MEAD
Physical Therapy

MEDICAL HISTORY FORM

Print Name: ____ **Male:** **Female:**

Present health concerns and date of onset (which brought you here today)

Past Injuries (please explain)

Past Rehabilitation (please explain)

Medications: Prescription and non-prescription medicine, vitamins, home remedies and herbs

Medication	Dose	Medication	Dose

Surgical History: Please provide a list of all significant surgeries and dates.

Surgery	Date

Allergies: Please list all allergic reactions to any medication/food/other.

Alergy	Reaction

Personal Medical History: Please indicate if you have had any of the listed medical problems.

Anemia

Arthritis

Diabetes Type 1

Diabetes Type 2

Epilepsy

Eczema

Hepatitis A

Hepatitis B

Hepatitis C

Asthma

Bleeding Disorder

High Cholesterol

High Blood Pressure

Heart Attack(s)

Kidney Disease

Migraine Headahes

Osteoporosis/Osteopenia

Osteoarthritis

Coagulation (bleeding disorder such as DVT)

Psoriasis

Rheumatoid Arthritis

Stroke

Staph Infections/MRSA

Tuberculosis

Problems with vision

Congenital Heart Disease: specifiy type ____

Cancer: specifiy type ____

Heart Problem: specify type ____

Thyroid Problem: specifiy type ____

*Height: _____________ *Weight: _____________

*Flu Shot Given? Yes: *Date: __________________

No: *If no, why not? ____

*Falls Risk Assessment: List any falls in the past year and any injuries due to fall:

Additional Information: Please list any information that we should know that was not listed above.

Print Name: ____

Signature: ____ Date: ________________________

**required by insurance*