Senior Fit Physical Therapy

MEDICAL HISTORY

Name: _____ Date: _____

Present Illness or Injury

For what condition or symptoms are we seeing you? _____

When did it begin (date and explain) _____

What treatment have you already received? _____

Other medical problems not listed (explain) _____

_____

_____

_____

Surgery (list all) **Date of Surgery**

_____

_____

_____

_____

_____

List Medications:	Frequency	Dosage

Past Medical History (please indicate if you have had any of the following conditions in the past or have currently)

Heart Disease/ Heart Attack	☐ Yes	☑ No
Arthritis	☐ Yes	☑ No
Epilepsy or Convulsions	☐ Yes	☑ No
Diabetes	☐ Yes	☑ No
Emphysema	☐ Yes	☑ No
Tuberculosis	☐ Yes	☑ No
Ulcers	☐ Yes	☑ No
Hernia	☐ Yes	☑ No
Venereal Disease	☐ Yes	☑ No
Thyroid Disease	☐ Yes	☑ No
Osteoporosis	☐ Yes	☑ No
Migraine Headaches	☐ Yes	☑ No
Fainting	☐ Yes	☑ No
Back Pain	☐ Yes	☑ No
Hemorrhoids	☐ Yes	☑ No
Do you have surgical implants?	☐ Yes	☑ No
High Blood Pressure	☐ Yes	☑ No
Stroke	☐ Yes	☑ No
Kidney/ Bladder Problems	☐ Yes	☑ No
Tumor or Cancer	☐ Yes	☑ No
Asthma/Chromic Bronchitis	☐ Yes	☑ No
Hepatitis	☐ Yes	☑ No
Blood Disorders	☐ Yes	☑ No
Congenital Abnormalities	☐ Yes	☑ No
Genital/ Gynecological Disorder	☐ Yes	☑ No
Alcoholism / Drug Abuse	☐ Yes	☑ No
Pacemaker	☐ Yes	☑ No
Allergies	☐ Yes	☑ No
Mental Disorder	☐ Yes	☑ No
Sinus Problems	☐ Yes	☑ No
Are you pregnant?	☐ Yes	☑ No

PAIN SCALE: Please choose which picture/numbers describe your pain at the present time: