DATE: _____

PATIENT: _____

willard PHYSICAL THERAPY

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PATIENT MEDICAL HISTORY

MEDICATIONS (LIST DOSAGE & FREQUENCY): _____

_____

ALLERGIES/REACTIONS: _____

_____

REFERRING PHYSICIAN NAME (IF APPLICABLE): _____

MEDICAL HISTORY (PLEASE INDICATE ALL THAT APPLY)

- ☐ CANCER
  - TYPE OF TREATMENT _____
- ☐ HEART DISEASE OR CONDITION:
  - HOW DO YOU MANAGE? _____
- ☐ HIGH BLOOD PRESSURE
  - HOW DO YOU MANAGE? _____
- ☐ DIABETES
- ☐ THYROID DISORDER
- ☐ BLOOD CLOTTING DISORDER / BLEEDING TENDENCY
- ☐ ANEMIA
- ☐ HEPATITIS
- ☐ LIVER DISEASE OR PROBLEM
- ☐ ASTHMA
- ☐ PNEUMONIA
- ☐ TUBERCULOSIS
- ☐ LUNG DISEASE
- ☐ STOMACH DISORDER/DISEASE
- ☐ COLONOSCOPY
- ☐ PEPTIC ULCER DISEASE
- ☐ EPILEPSY
- ☐ NEUROLOGICAL DISORDER
- ☐ MUSCLE/BONE DISORDER
- ☐ URINARY INCONTINENCE
- ☐ ALTERED SENSATION AROUND ANUS OR VAGINA
- ☐ MIGRAINES
- ☐ DEPRESSION
  - HOW DO YOU MANAGE? _____
- ☐ HIGH CHOLESTEROL
  - HOW DO YOU MANAGE? _____
- ☐ MAJOR INJURY
  - TYPE OF INJURY? _____
- ☐ OTHER

_____

_____

SOCIAL HISTORY

DO YOU SMOKE? ☐ YES ☐ NO

HOW MANY PACKS PER DAY? _____

HOW LONG HAVE YOU SMOKED? _____

OCCUPATION: _____

ARE YOU ON A SPECIFIC DIET? ☐ YES ☐ NO

IF YES, WHAT TYPE OF DIET? _____

DO YOU HAVE ANY ACTIVITY LIMITATIONS? ☐ YES ☐ NO

IF YES, WHAT TYPE OF LIMITATIONS? _____

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

IF YES, WHAT TYPE OF EXERCISE? _____

SURGICAL HISTORY INCLUDING DATES:

_____

_____

DO YOU HAVE OSTEOARTHRITIS? ☐ YES ☐ NO

IF YES, WHICH JOINTS? _____

DO YOU HAVE RHEUMATOID ARTHRITIS? ☐ YES ☐ NO

IF YES, WHICH JOINTS? _____

DO YOU HAVE OSTEOPOROSIS/OSTEOPENIA? ☐ YES ☐ NO

ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____