

Greater Rochester Physical Therapy Medical History Form

An Updated Medical History Form Must Accompany All New Prescriptions

Name: _____ Age: _____

Primary Physician: _____ Physician Phone #: _____

Please check any item below if affected by it in the past or present:

| | | | |
|----------------------------|--|------------------------------|--|
| Artificial Joints | | Kidney disease | |
| Asthma | | Lupus | |
| Bowel/Bladder incontinence | | Liver disease | |
| Brain Injury | | Open wounds/skin ulcerations | |
| Cancer | | Osteoarthritis | |
| Diabetes | | Osteopenia | |
| Depression | | Osteoporosis | |
| Chemotherapy/Radiation | | Pacemaker | |
| Epilepsy | | Psychiatric care | |
| Fainting/Dizziness | | Rheumatoid arthritis | |
| Gout | | Respiratory disease | |
| Hearing Difficulties | | Seizures | |
| Heart disease/problems | | Stroke | |
| Hear murmur | | Tuberculosis | |
| High blood pressure | | Visual difficulties | |

Explanation of checked conditions (if needed): _____

Is your current diagnosis/condition related to a work injury? (Circle) Yes No

| Current Medications: | Dosage: | Current Medications: | Dosage: |
|-----------------------------|----------------|-----------------------------|----------------|
| 1. _____ | _____ | 6. _____ | _____ |
| 2. _____ | _____ | 7. _____ | _____ |
| 3. _____ | _____ | 8. _____ | _____ |
| 4. _____ | _____ | 9. _____ | _____ |
| 5. _____ | _____ | 10. _____ | _____ |

OVER

Allergies: _____

Are you currently pregnant or nursing? (Circle) Yes No Not Applicable

Surgical History:

Date:

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

Are you receiving home care physical therapy services? (Circle) Yes No

Date you will be returning to your referring physician? _____

Patient Signature: _____

Parent/Guardian Signature: _____

Date: _____