PhysicalTherapy of Wimberley

Patient Name_________________________________Date of Birth______________________

PAST MEDICAL HISTORY

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Arthritis	Yes ___No____	High Blood Pressure	Yes ___No____
Asthma / Chronic Bronchitis	Yes ___No____	HIV / AIDS	Yes ___No____
Bowel / Bladder Problems	Yes ___No____	Osteoporosis	Yes ___No____
Cancer	Yes ___No____	Rheumatoid Arthritis	Yes ___No____
Chest Pain	Yes ___No____	Stroke	Yes ___No____
Diabetes	Yes ___No____	Emphysema	Yes ___No____
Epilepsy / Seizures	Yes ___No____	Tobacco	Yes ___No____
Alcoholism	Yes____No____	Type ___________	Packs Per Day____
Drug Abuse	Yes____No____	Quit date_________/_________/_____	
Heart Disease / Attack	Yes ___No____	Hepatitis	Yes ___No____
Do you have a pacemaker?___________		Pregnant	Yes ___No____

CURRENT SYMPTOMS

Where are you currently having symptoms?____

What date did your current symptoms start?____

How did symptoms start (Gradual, Suddenly, Injury?__________________________________

Have you received any other treatment for the current symptoms?________________________
Recent Surgery____ Date__________________
Hospital____

**Have you done Home Health for this problem – YES ________Discharge Date____________

****Have you FALLEN in the last 12 months Yes__________NO_________**
If YES how many times?____________
Were you injured as a result of the Fall?____

____

____

Do you have any current or past health or medical problems that are not listed above?

____

____

PAST MEDICAL HISTORY

Please list all surgeries and the approximate date of the operation:

____

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Weight: ***Height:*** ***BMI***_______
BP ________/_______mmHg
HR_________BPM

Please PRINT all medications (Over the Counter, Prescriptions, Herbals, and Vitamins/Mineral/ dietary (nutritional supplements) that you are currently taking:

Medication Name	*Medication Dosage*	*Frequency*	*Route of Administration*

If your medications change at any time, please notify PT staff with new medication list. Int. _______