GPPT - PATIENT MEDICAL HISTORY FORM

Patient Name:	Age:
SS Number:	Date of Birth:

In case of emergency, please notify _____ Phone # _____

Why are you seeing the Physical Therapist today?

_____

Describe injury/present illness in detail _____

_____

Past Medical History

Arthritis	No	Yes	Kidney Disease	No	Yes
Cancer	No	Yes	Liver Disease	No	Yes
Diabetes (on insulin?)	No	Yes	Neurological Disorder	No	Yes
Epilepsy	No	Yes	Polio	No	Yes
Heart Disease/Hypertension (high blood pr.)	No	Yes	Respiratory Disease /TB	No	Yes
Hepatitis	No	Yes	Stroke	No	Yes
HIV or other Immune deficiency	No	Yes	Thyroid Disease	No	Yes
Infections	No	Yes	Vascular Disease	No	Yes

MEDICATION LIST

NAME AND DOSAGE

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Review of Systems

Are you currently having or have you had problems with:

Allergies	No	Yes	Eyes/ visual disturbance	No	Yes
Blackout/fainting	No	Yes	Fever/Chills/sweats/fatigue	No	Yes
Bladder /bowel movement	No	Yes	Headache/dizziness	No	Yes
Bleeding problems	No	Yes	High blood pressure	No	Yes
Blood Clots	No	Yes	Lower back pain	No	Yes
Changes in skin color /texture	No	Yes	Lungs, Breathing/cough	No	Yes
Chest pain/palpitation	No	Yes	Muscle/bone/joint pain	No	Yes
Depression/anxiety	No	Yes	Numbness/tingling	No	Yes
Digestion	No	Yes	Swelling/dislocation - extremity	No	Yes
Ears, Nose, Throat	No	Yes	Weight loss or gain	No	Yes

Describe all 'YES' answers:

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____