

**LEPRE PALADIN PHYSICAL THERAPY
PATIENT MEDICAL HISTORY FORM**

Name: _____ ID# _____ DOB: _____

Occupation: _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY: (please check any condition you have a history of. Items not checked are understood to be negative.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Heart Rate | <input type="checkbox"/> Chronic Lung Problem | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Angina (Chest Pain) | <input type="checkbox"/> Diabetes Rx Dependent (YES/NO) | <input type="checkbox"/> History of Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Recent Weight Loss/Gain |
| <input type="checkbox"/> Bowel or Bladder Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Heartburn/Intestinal Upset | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problem (Hyper/Hypo) |

Other: _____

- | | | |
|--|--------|-------------------------|
| Do you have a history of fractures? | YES NO | Where? _____ |
| Do you have a history of back/neck pain? | YES NO | When? _____ |
| Do you have any metal implants? | YES NO | Where? _____ |
| Do you smoke? | YES NO | How much per day? _____ |
| Do you exercise regularly? | YES NO | How often? _____ |
| Do you have any known allergies? | YES NO | Please list _____ |
| Are you allergic to latex? | YES NO | |
| Are you pregnant or suspect pregnancy? | YES NO | |

MEDICATIONS: Please check if you are taking any of the following (Please list name of medications)

- | | | |
|--|--|---|
| <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> Heart Medication | <input type="checkbox"/> Anti-coagulants (blood thinners) |
| _____ | _____ | _____ |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Pain Killers | <input type="checkbox"/> Diabetes Medication (i.e. Insulin) |
| _____ | _____ | _____ |
| <input type="checkbox"/> Steroids (Cortisone) | <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Other Medications |
| _____ | _____ | _____ |

SURGERIES: Please list all surgeries, including date:

