PATIENT MEDICAL HISTORY

Patient's Name ____ **Date**______________

Do you or have you ever had any of the following?

Condition	Yes ✓	Date Diagnosed	Current Status
Pacemaker			
Arthritis			
Asthma/Breathing Disorder			
Allergies/Hay Fever			
Back Pain/Injury			
Bleeding Disorder			
Cancer			
Diabetes			
Heart Attack Problems			
Head Injury			
Hearing/Vision Problems			
High Blood Pressure			
Kidney/Bladder Problems			
Osteoporosis			
Stroke			
Ulcer/Stomach Problems			
Bowel Problems			
Currently Pregnant			
Implants (Location________)			
Total Joint Replacement			

Other medical conditions: ____

I verify the above information is correct and will be used only by the Physical Therapist and his staff to ensure my health and safety. **Patient's Initials** ________

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