peterson² PHYSICAL THERAPY

## PATIENT MEDICAL HISTORY

Patient's Name _____ Date: _____

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

| Condition | Yes ✓ | Condition | Yes ✓ |
|---|---|---|---|
| Anxiety/Panic Disorders | | Prior Heart Attacks | |
| Arthritis (Rheumatoid or Osteoarthritis) | | Hearing Impairment | |
| Asthma | | Visual Impairment | |
| Chronic Obstructive Pulmonary Disease, Acute Respiratory Distress Syndrome, or Emphysema | | Neurological Disease (Multiple Sclerosis, Parkinson's, etc.) | |
| Congestive Heart Failure/Heart Disease | | Osteoporosis | |
| Chest Pain (angina) | | Peripheral Vascular Disease | |
| Back Pain (back degeneration, Spinal Stenosis, or severe chronic back pain) | | Upper Gastrointestinal Disease (ulcer, hernia, or reflux) | |
| Depression | | Stroke or Mini Stroke (TIA) | |
| Diabetes (Types I or II) | | Dementia | |

Height _____Weight_____

| Condition | Yes ✓ | Current Status | Date Diagnosed |
|---|---|---|---|
| Pacemaker | | | |
| Allergies/Hay Fever | | | |
| Bleeding Disorder | | | |
| Bowel Problems | | | |
| Kidney/Bladder Problems | | | |
| Cancer | | | |
| High Blood Pressure | | | |
| Head Injury | | | |
| Implants (Location_____) | | | |
| Total Joint Replacement | | | |
| Pregnant | | | |

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 _____