# Frankfort Physical Therapy, LLC.

7777 W. Lincoln Hwy * Suite D * Frankfort, Illinois 60423 * (815) 806-8777

## Patient Medical History Form

**1. Name:**_____________________________________________ **2. Age:**________________

**3. Occupation:**_____________________________________________________________________

-Type of work, (examples: lifting, prolonged sitting, standing, etc.)

_____________________________________________________________________________

**4. Past Medical History:**

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | Yes No | | Pacemaker | Yes No | |
| Heart Condition | Yes No | | Seizures | Yes No | |
| Strokes | Yes No | | Cancer | Yes No | |
| Diabetes | Yes No | | Other | Yes No | |

If yes, describe: ___________________________________________________________

Have you been admitted to the hospital or undergone any surgical procedures during the past 5 years? YES NO What was the condition? _____________________________________

What hospital? __________________________________ Is this condition the reason you were referred to Frankfort Physical Therapy? YES NO

Have you received any physical therapy treatments in the past 5 years? YES NO

If YES, for what condition, and was the treatment effective? ___________________________

____________________________What was this treatment? ____________________________

Have you had any other previous medical problems or surgeries? YES NO

If YES, please specify: _____________________________________________________________

Did you receive any special tests while in the hospital or as an outpatient?

(Ex: Cat scan, EMG, EKG, Cardiac Stress) YES NO

If YES please specify: ______________________________________________________________

Have you had any previous orthopedic problems? YES NO

If YES, please specify: _____________________________________________________________

**5. Medications?** What type and for what? ___________________________________________

**6. Exercise/Activity level:** 0___ 1-2___ 3-5___ 6-7 ___ DAYS/WK

**7. Name of your orthopedic doctor:** _____________________________________________

**8. Name of your family or primary doctor:** _______________________________________

**9. ARE YOU ALLERGIC TO:** Latex or Lanolin YES NO Other:________________________

**PATIENT SIGNATURE:** ________________________________

**DATE:** __________________________