

Manteno Physical Therapy, LLC.

19 West Division Street * Manteno, Illinois 60950 * (815) 468-7300

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 Manteno 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: _____