Patient Name: ______________________________

MEDICAL HISTORY FORM

(please check if you have or have had any of the conditions)

□Heart Problems______ □Chemical Dependency □Infectious Disease
□Stroke □Depression □Skin Disease
□High Blood Pressure □Anxiety Disorder □Head Injury
□Kidney Problems □Multiple Sclerosis □Peripheral Vascular Disease
□Seizures/Epilepsy □Parkinson's Disease □Lymphedema
□Osteoporosis/Osteopenia □Anemia □Cancer____________
□Asthma □Blood Disorder □Prostate Disease
□Emphysema □Stomach Ulcers □High Cholesterol
□Headaches/Migraines □GERD □Diabetes_____________
□Rheumatoid Arthritis □Osteoarthritis □____________________

Last MD Physical Examination: _____________(Date)

Primary Care MD: ____

Specialist MD: ____

Date PMHX Updated:______________________________

Date PMHX Updated:______________________________

Date PMHX Updated:_____________________________

Please list any **MEDICATIONS** including over the counter medications that you are currently taking: □See Copy____

____

____

____

ALLERGIES:____

SURGICAL HISTORY Date

____

____

____

CPR

Have your completed an advance directive for DNR (Do not resuscitate) which indicates no cardiopulmonary resuscitation (CPR) if you heart stops or if you stop breathing? □ YES □NO

If answered yes, please provide facility with copy of advanced directives.

SOCIAL/HEALTH HABITS

What is your occupation? ____________

How many days a week do you exercise? _____________

What type of exercise do you do? _____________

Marital Status _____________

Home Environment: Home/Apartment ___#Steps to enter ___#Steps to 2nd floor

Are there any religious/cultural beliefs that may affect your care that we should be aware of?

____

Are you currently seeing anyone else for your condition?

□Acupuncturist □Chiropractor □Massage Therapist □Family Practitioner □Cardiologist □Orthopedist □ Podiatrist □Internist □Neurologist □Rheumatologist □Psychologist □OB/GYN □Pediatrician □ _____________

CONTACT INFORMATION

□ I give Gambrill's Physical Therapy permission to email me regarding my physical therapy care as well as upcoming events and newsletters. EMAIL ADDRESS: ________

□ I give Gambrill's Physical Therapy permission to use this phone number for all correspondence. PHONE NUMBER :_____________________________________