PHYSICAL THERAPY MASTERS, LLC

PERTINENT MEDICAL HISTORY

Patient Name: ____

Date: ____

Please indicate whether you have had any of the following conditions:

Heart disease or heart attack	□ yes	□ no
Rheumatic fever	□ yes	□ no
Stroke	□ yes	□ no
Epilepsy or convulsions	□ yes	□ no
Kidney or bladder problems	□ yes	□ no
Diabetes	□ yes	□ no
Tumor or cancer	□ yes	□ no
Respiratory disease	□ yes	□ no
Pneumonia or emphysema	□ yes	□ no
Tuberculosis	□ yes	□ no
Asthma	□ yes	□ no
Hepatitis	□ yes	□ no
Peptic ulcer or pancreatitis	□ yes	□ no
Anemia or other blood disorder	□ yes	□ no
Bleeding disorders	□ yes	□ no
Jaundice/Hernia	□ yes	□ no
Thyroid disorders	□ yes	□ no
Venereal disease	□ yes	□ no
Genital or gynecological disorders	□ yes	□ no
Congenital abnormalities	□ yes	□ no
Are you now pregnant?	□ yes	□ no
Do you have a pacemaker?	□ yes	□ no
Do you have any surgical implants?	□ yes	□ no

ALLERGIES

Please list ALL allergies:

Penicillin or other antibiotics	□ yes	□ no
Morphine, codine, or other narcotics	□ yes	□ no
Novacain, or other local anesthetics	□ yes	□ no
Iodine compounds	□ yes	□ no

Other allergies?

____

____

SURGERY

Please list ALL previous operations, fractures and/or other serious injuries:

DATE MO/YR	SURGERY (TYPE)	AGE

FAMILY MEDICAL HISTORY

Has any blood relative ever had any of the following:

Cancer	□ yes	□ no
Heart disease	□ yes	□ no
Arthritis	□ yes	□ no
Tuberculosis	□ yes	□ no
High blood pressure	□ yes	□ no
Bleeding tendency	□ yes	□ no
Diabetes	□ yes	□ no
Stroke	□ yes	□ no
Gout	□ yes	□ no

MEDICATIONS

Please list ALL present medications.
Please include the dosage and frequency.

MEDICATION	DOSAGE	FREQUENCY

PATIENT'S SIGNATURE DATE