PLYMOUTH
PHYSICAL THERAPY SPECIALISTS
Orthopedics • Sports Medicine • Industrial Rehabilitation

PATIENT NAME: _____ **DATE:** _____

DATE OF LAST HOSPITILIZATION, AND REASON:

_____
_____
_____
_____

DIAGNOSTIC TESTS:

CT SCAN_____ **LAPAROSCOPY** _____
MRI_____ **ULTRASOUND** _____
CYTOSCOPY_____ **OTHER** _____

SURGICAL HISTORY- Please list all the surgeries you have had and note the date.

_____
_____
_____
_____

SOCIAL HISTORY

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ LIFE PARTNER ☐ COMMON LAW SPOUSE

WOMEN: DATE OF LAST MENTRUAL PERIOD: _____ ARE YOU PREGNANT?: _____

NUMBER OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____
ARE YOU PRESENTLY NURSING / BREASTFEEDING?: _____

PLEASE LIST THE YEAR OF EACH CESAREAN SECTION, VAGINAL, EPISIOTOMIES, SUCTION, FORCEPS DELIVERY:

_____
_____
_____

ALCOHOL CONSUMPTION: NO _____YES _____ OCCASIONAL/SOCIAL _____ #OF DRINKS PER DAY _____

TOBACCO USE: NO _____ YES _____ # OF PACKS/DAY _____ #OF CIGARETTES/DAY

CAFFEINATED BEVERAGES (COFFEE, SODA, TEA) # GLASSES PER DAY _____

CURRENT MEDICATIONS

Please list ALL medications you are currently taking, including any over the counter drugs on the medication card provided.

_____
_____
_____
_____

ALLERGIES

Please list ALL types (drug, seasonal, pets, animals, environmental, foods, latex)

_____
_____
_____
_____

Have you ever been verbally, emotionally, sexually, or physically harmed or threatened by your partner or anyone else?
☐ YES ☐ NO
Do you feel afraid or unsafe with you partner or anyone else? ☐ YES ☐ NO
Is anyone mususing your money, food, housing, or not allowing you to obtain healthcare? ☐ YES ☐ NO
Are you thinking or suicide? Do you have thoughts of ending your life? ☐ YES ☐ NO