PLYMOUTH
PHYSICAL THERAPY SPECIALISTS
Orthopedics • Sports Medicine • Industrial Rehabilitation

Patient Name:_____

MEDICAL HISTORY

Allergies: _____
_____

Are you currently seeing any of the following?

YES NO Medical Doctor (MD) YES NO Chiropractor YES NO Dentist
YES NO Osteopath (DO) YES NO Physical Therapist YES NO Podiatrist

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc): _____
_____

Please indicate if you have EVER been diagnosed as having any of the following conditions: (answer all questions)

Y N Cancer. If yes, describe what kind:_____
Y N Heart problems_____
Y N Pace maker_____
Y N Circulation problems_____
Y N High blood pressure_____
Y N Stroke_____
Y N Respiratory problems_____
Y N Infectious disease_____
Y N Hepatitis_____
Y N Tuberculosis_____
Y N Anemia_____
Y N Thyroid problems_____
Y N Kidney disease_____
Y N Diabetes_____
Y N Epilepsy_____
Y N Rheumatoid arthritis_____
Y N Other arthritic conditions_____
Y N Currently pregnant_____
Y N Metal or plastic implants_____
Y N Osteoporosis_____

Please list ALL surgeries and dates_____

Patient Name:_____

What are your symptoms at the present time?_____
What relieves your symptoms?_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Y N Aspirin
Y N Tylenol
Y N Advil/Motrin/Ibuprofen
Y N Laxatives
Y N Decongestants
Y N Antihistamines
Y N Antacid
Y N Vitamins/mineral supplements
Y N Other_____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or patches):_____

Have you recently noted:

Y N Weight loss/gain
Y N Nausea/vomiting
Y N Fatigue
Y N Weakness
Y N Fever/chills/sweats
Y N Numbness or tingling

I have completed this form to the best of my knowledge and have not withheld any information. Form reviewed with patient? ___Yes ___No

_____ _____
Patient Signature Date Therapist Signature Date