Patient Medical History

Patane & Associates
Physical Therapy

Patient Name: ______________________________ Date: ______________________________

Age: ______________ Height: __________________ Weight: ________________________

Chief Complaint: o Pain o Numbness o Weakness o Stiffness o Swelling o Popping/Grinding o Unstable
o Other ____

Body Part Affected : o Right ◻ Left ____

Date of injury or onset of symptoms ________________

Where did the injury/symptoms occur? o at home o at work o during sports/recreational o car accident o at school
o Other ____

How did the injury/symptoms occur? o sudden/traumatic o lifting/bending o gradual onset o injury relating to a fall
o recurrence of previous injury o Other ________________________

Allergies: o No known allergies o Latex o Soy o Eggs o Penicillin o Sulfa o Iodine o Shellfish o Radiological dyes
o Other ____

List prescription and non-prescription medications, including vitamins, herbal and nutritional supplements.

Medication	Dosage	How Often

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Current Medications: o None

Review of Systems: (Check all that apply)

General: o NONE o Excessive fatigue o Weakness o Fever o Exercise intolerance oOther

Eye Problems: o NONE o Blurred vision o Double vision o Cataracts o Glaucoma o Light sensivity
o Glasses/Contacts o Other ____

Ears, Nose,

Throat, Mouth: o NONE o Difficulty swallowing o Nose bleeds o Sore throat o Ear pain o Seasonal allergies
o Hard of hearing o Other ____

Cardiovascular: o NONE o High blood pressure o Heart attack o Chest pain o Palpitation s o Blood clots
o Murmur o Other ____

Respiratory: o NONE o Shortness of breath o Asthma o Sleep apnea o chronic cough o wheezing
o Other ____

Stomach/Intestinal: o NONE o Heartburn o Nausea o Vomiting o Abdominal pain o Gallbladder problems
o Other____

Kidney/Bladder: o NONE o Painful urination o Frequent urination o Incontinence o Frequent bladder infection

Musculoskeletal: o NONE o Muscle cramps o Joint stiffness o Joint pain o Joint swelling o Other __________

Skin Problems: o NONE o Itching o Excessive dryness o Hives o Dermatitis o Other ________________

Neuro/Psychological: o NONE o Anxiety o Depression o Headaches o Memory loss o Seizures o ADD/ADHD
o Other ____

Endocrine Problems: o NONE o Weight gain o Weight loss o Diabetes o Thyroid problems o Gout o Liver problems
o Other

Hematologic: o NONE o Bruise easily o Prolonged bleeding o Anemia o Other ________________

Reproductive: o NONE o Pelvic pain o Heavy Bleeding o Cysts o Other ________________

If female, are you pregnant? o Yes o No Date of last menstrual period:________________

Past Medical History: o NONE o Heart Attack o Stroke/HA o Cancer (What type?)____________________

Please list other illnesses we should know about: ____________________

Have you had surgery in the past? o No o Yes (if yes, please list)____________________

Have you had anesthesia in the past? o No o Yes
Did you have complications from anesthesia? o No o Yes (if yes, please explain)____________________

Do you or have you had any infectious diseases? o NONE
o IIlV/AIDS o Hepatitis (Type)______o Tuberculosis (When?) o Sexually Transmitted Diseases
o Other

Family History: (Check all that apply)
o Heart Disease o Stroke o Arthritis o Osteoporosis o Alzheimer's o Gout o Cancer (type) ____________________
o Other ____________________

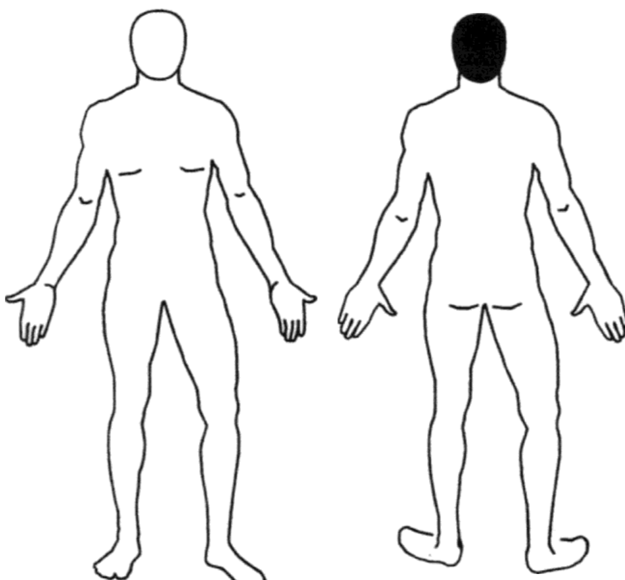
Social History:
Do you smoke? o Yes o No o Cigarettes______packs/day o Cigars per day o Pipe_______per day
Do you chew tobacco? o Yes o No
Do you use recreational drugs? o Yes o No
Do you drink alcoholic beverages? o Yes o No
If yes, how often? o Socially o Rarely D Daily drinks/day o Weekly

Osteoporosis Evaluation (Check each block that applies to you)
o Female
o Underweight
o Smoking
o Drink alcohol (3 drinks per day)
o Have a family member with a hip fracture by age of 50
o Menopause or surgical removal of ovaries
o Habitual low calcium intake
o Excessive carbonated drink consumption (4 or more per day)
o In-active (less than 20 minutes of weight bearing exercise 3 days/week
o Height loss in the past year

Pain Scale – If you are having pain, please rate the intensity of your pain on a scale of 1 – 10.

0 – No pain	1	2	3	4	5	6	7	8	9	10 – Extreme Pain

PLEASE INDICATE BELOW WHERE YOUR SYMPTOMS ARE LOCATED



KEY
Numbness - +++++++++++++++++++++++++
Pins & Needles - 000000000000000000000000
Burning Pain - XXX:XXXXXXXXXXXXXXX
Stabbing Pain - //////////////I/////////I///I/I////I/////I///