Advanced Care
PHYSICAL THERAPY

-PATIENT MEDICAL HISTORY FORM-

Patient's Name:_____ Today's Date:_____

Date of Birth:_____ Primary Physician:_____

Weight:_____ Physician Phone:_____

Height:_____

Have you experienced any of the following symptoms? (circle one)

Change in bowel/bladder habits? **YES/NO** Unexplained weight lose? **YES/NO** Fatigue? **YES/NO**

Which of the following conditions are you currently being treated or have been treated for in the past? (please check all that apply)

- ☐ Heart Disease/Murmur/Angina
- ☐ Diabetes
- ☐ Seizures
- ☐ Lung Problems/cough
- ☐ Low blood pressure
- ☐ Neurological problems
- ☐ Depression/Anxiety
- ☐ Other;
- ☐ Shortness of breath
- ☐ High Cholesterol
- ☐ Kidney/Bladder Problems
- ☐ Stroke
- ☐ Headaches/Migraines
- ☐ Cancer
- ☐ Ulcers/Colitis
- ☐ Eye Disorder/Glaucoma
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Liver Problems/Hepatitis
- ☐ Arthritis
- ☐ Anemia or blood problems
- ☐ Thyroid problems

Please list any current or past medical treatment not listed above:

Please list past surgeries:

Medications, please list:

Please list any allergies:

By signing below, I hereby certify that to the best of my knowledge all the information on this form is accurate and complete, true, and accurate:

Patient/Legal Guardian Signature:_____ Date:_____