# *Jacksonville Physical Therapy*

## MEDICAL HISTORY

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Patient's Name _____ Date: _____

1. Please describe your condition and its duration_____
_____

2. Make a check if you have **EVER** been diagnosed with any of the following conditions:

| | | | |
|---|---|---|---|
| __High blood pressure | __Heart disease | __Cancer | __Stomach problems |
| __Osteoarthritis | __Pacemaker/defibrillator | __Diabetes | __Multiple Sclerosis |
| __Fractures | __Chest pain/angina | __Stroke/TIA | __Headaches |
| __Joint Replacement | __Fainting spells | __Epilepsy/Seizures | __Fibromyalgia |
| __Metal implants | __Asthma/COPD | __Parkinson's | __Rheumatoid Arthritis |
| __Swelling | __Peripheral neuropathy | __Depression | |
| __Osteoporosis | __Circulation problems | __Visual Problems | |
| __Loss of Balance | __Vascular Disease/DVT | __Bowel/bladder dysfunction | |
| __Dizzy spells | __Infectious disease (TB, hepatitis, HIV, pneumonia, etc) | | |

__Other_____

__Have you had any falls? If so, how many?____ Date of most recent fall? _____

List surgeries you have had _____
_____
_____

**Check if you have had any of the following in the past 3 years:__**car accident __x-ray __MRI
__CT scan __EEG __EKG __Echocardiogram __Angiogram __Stress test __ER care
__Myelogram__Mammogram __Nerve conduction test __Biopsy __Blood test __Urine test
__Doppler/ultrasound_____

3. How would you describe your general health?
__Excellent __Very Good __Good __Fair __Poor

4. Do you have skin allergies? If so, list to what you are allergic :_____
_____

5. Do you use tobacco? __Yes __No

6. Female patients: Are you now pregnant? If so, please indicate due date: _____

7. Check if you have seen any of the following providers in this calendar year?
__Chiropractor __Podiatrist __Neurologist __Orthopedist __Speech Therapist __Rheumatologist
__Physical Therapist __General Practitioner/Internist __Other_____

8. Please list your goals for physical therapy:_____
_____

9. Identify three activities you are unable to do or have difficulty with:

1._____ 2._____ 3._____

*OFFICE USE ONLY: Reviewed and discussed by therapist: (PT initial)_____ Date:_____*