PATIENT MEDICAL HISTORY

St. John Physical Therapy

Name: _____ Date of Birth: _____

Referring Physician: _____ Family Physician: _____

Date of Injury: _____

If not an injury, date of onset of symptoms: _____

Date of 1st doctor visit for this injury: _____

Are you aware of what your diagnosis is? O Yes O No

What are your rehabilitation expectations or goals? _____

_____

_____

Occupation: _____ or O Retired O Student

Work Status: O Full-time O Part-time O Self-employed O Unemployed O Off work

Last date worked due to this injury: _____ Date returned to work after injury: _____

Type of surgery? _____

Approximate date of surgery: _____

Please list any medications (prescription and non prescription) you are currently taking: _____

_____

Have you had any of the following medical or rehabilitative service for this injury/episode?

X-Ray	O Yes	O No	Myelogram	O Yes	O No	General Practitioner	O Yes	O No
MRI	O Yes	O No	Physical Therapy	O Yes	O No	Orthopedist	O Yes	O No
CT-Scan	O Yes	O No	Occupational Therapy	O Yes	O No	Neurologist	O Yes	O No
EMG / nerve conduction	O Yes	O No	Message Therapy	O Yes	O No	Emergency room care	O Yes	O No

Have you had any of the following medical or rehabilitative service for this injury/episode?

Constitutional

General Good Health	O Yes	O No
Recent weight changes	O Yes	O No
Fatigue	O Yes	O No
Night sweats / fevers	O Yes	O No

Cardiovascular

Angina / chest pain	O Yes	O No
Coronary artery disease	O Yes	O No
Heart Surgery	O Yes	O No
Pacemaker	O Yes	O No

Musculoskeletal

Muscle pains or cramps	O Yes	O No
Stiffness/swelling in joints	O Yes	O No
Joint pain	O Yes	O No
Osteoporosis	O Yes	O No

Endocrine

Excessive thirsts / urination	O Yes	O No
Thyroid disease	O Yes	O No
Hormone problem(s)	O Yes	O No

Ear / Nose / Throat / Mouth

Hearing loss/ringing in ears	O Yes	O No
Sinus problems	O Yes	O No
Nose bleeds	O Yes	O No
Sore throat	O Yes	O No
Voice changes	O Yes	O No

Continued on next page ↵

PATIENT MEDICAL HISTORY: PAGE 2

Continued from page 1.

Have you had any of the following medical or rehabilitative service for this injury/episode?

Respitory

Shortness of Breath	O Yes	O No
Excessive coughing	O Yes	O No
Asthma	O Yes	O No
Bronchitis	O Yes	O No
Emphysema	O Yes	O No

Neurological

Frequent headaches	O Yes	O No
Seizures/Epilepsy	O Yes	O No
Numbness/Tingling	O Yes	O No
Dizziness	O Yes	O No
Weakness	O Yes	O No
Stroke/TIA	O Yes	O No

Hematologic / Lymphatic

Bruise easily	O Yes	O No
Slow to heal	O Yes	O No
Enlarged glands	O Yes	O No

Eyes

Wear glasses/contacts	O Yes	O No
Blurred/double vision	O Yes	O No
Eye disease or injury	O Yes	O No
Glaucoma	O Yes	O No

Allergies

Food	O Yes	O No
Medicine	O Yes	O No

Gastrointestinal

Nausea / Vomiting	O Yes	O No
Abdominal pains	O Yes	O No
Rectal bleeding	O Yes	O No
Blood in urine	O Yes	O No
Kindney stones	O Yes	O No

Other

Changes in hair or nails	O Yes	O No
Rashes or itching	O Yes	O No
Breast lump	O Yes	O No
Breast pain or discharge	O Yes	O No
Changes in menstral cycle	O Yes	O No
Tuberculosis	O Yes	O No
Cancer	O Yes	O No
Chemotherapy or radiation	O Yes	O No
HIV / AIDS	O Yes	O No
Diabetes	O Yes	O No
Blood clots	O Yes	O No
Depression	O Yes	O No
Insomnia	O Yes	O No
Confusion or memory loss	O Yes	O No
Memory loss	O Yes	O No
Do you smoke	O Yes	O No
Use tobacco products	O Yes	O No
Are you pregnant	O Yes	O No