FOLEY PHYSICAL THERAPY

MEDICAL HISTORY

Name _____ **Date** _____

PAST HISTORY

Have you had any of the following?

☐ High blood pressure	☐ Heart condition	☐ Stroke	☐ Osteoporosis
☐ Peripheral neuropathy	☐ Seizures/epilepsy	☐ Vision problems	☐ Diabetes
☐ Frequent/severe headaches	☐ Fainting/dizziness	☐ Emphysema	☐ Cancer
☐ Bowel/bladder problems	☐ Hearing problems	☐ Arthritis	☐ Asthma

☐ Other _____

Have you had a fall in the past year?	YES	NO	-	If yes, how many? _____
Do you have a history of fractures?	YES	NO	-	Where? _____
Do you have a metal implant?	YES	NO	-	Where? _____
Do you smoke?	YES	NO	-	How much per day? _____
Do you exercise regularly?	YES	NO	-	How often? _____
Do you have any allergies?	YES	NO	-	Please list _____
Are you or may you be pregnant?	YES	NO		

Surgeries

_____ Date _____

_____ Date _____

CURRENT CONDITION

What is the problem to be treated? _____

Have you had similar symptoms before? _____

Have you had previous treatment for this condition? _____

Diagnostic Tests

Please check any tests or procedures that have been done for your current condition

☐ X-rays	☐ MRI	☐ CT scan	☐ Bone scan
☐ EMG	☐ Blood work	☐ Bone density	☐ Ultrasound

Medications

List the medications (prescribed or over the counter) or supplements that you are taking

_____

_____