**Advantage Physical Therapy**

**Medical History**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of next physician’s visit? \_\_\_\_\_\_\_\_\_

Date of Injury:\_\_\_/\_\_\_/\_\_\_\_\_ Have you had a related surgery? □ Yes □ No

Have you ever had these symptoms before? □ Yes □ No Date of surgery:\_\_\_/\_\_\_/\_\_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ Blood Pressure (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following:

Yes No Yes No

Diabetes □ □ Seizures □ □

High Blood Pressure □ □ Allergies □ □

Heart Disease □ □ Arthritis □ □

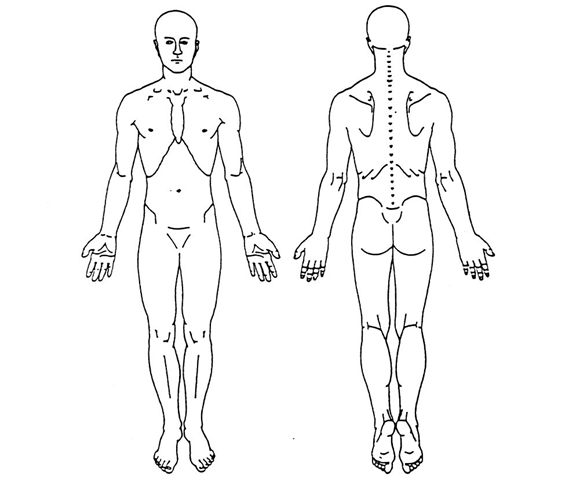
Heart Attack □ □ Osteoporosis □ □

Pace Maker □ □ Infectious Disease □ □

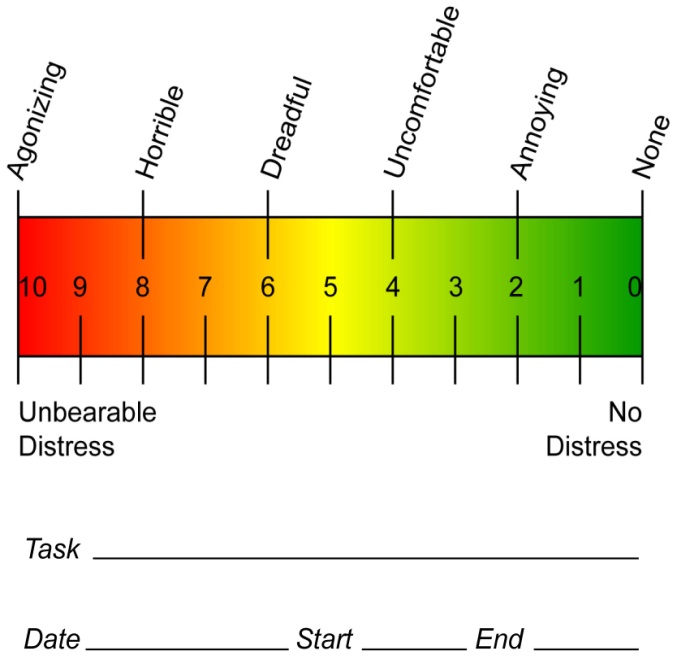
Pregnant □ □ Depression □ □

Cancer □ □ Smoking □ □

Asthma □ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate areas of pain:

Circle number that corresponds with worst and least pain intensity:



Are you presently taking medication? □ Yes □ No

If yes, please list what medications and for what condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any other information regarding your past medical history that we should know about? \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_