Mary Chu, PT DPT
(619)880-0748

Patient Medical History Form

Name: _____ Date: _____ Height: _____ Weight:_____ Age:_____

Do you: Have a Pacemaker Yes / No Smoke Yes / No Take Blood Thinners Yes / No
Are you Pregnant Yes / No

List any allergies: _____ Latex Yes / No

Do you exercise regularly? Yes / No If Yes, how often and describe what you do: _____
_____

Type of work and physical demands: _____

Past Medical History. Please circle any condition(s) you were told you have or had.

Cancer Active Remission
Other arthritic conditions
Thyroid Problems
Heart Problems _____
Depression
Diabetes Type I II
Chest pains / Angina
Lung problems
Osteoporosis
High blood pressure
Tuberculosis
Multiple Sclerosis
Blood Clots
Pneumonia
Epilepsy / Seizures
Anemia
Asthma
Eye problems / Infection
Stroke / TIA
Bladder / Urinary Tract infection
Ulcers
Bone or joint infection
Kidney problem / Infection
Crohn's Disease / G.I. issues
Rheumatoid Arthritis
STD / HIV
Liver problems
Lyme Disease
Pelvic Inflammatory Disease
Hepatitis

Have you ever been involved in a motor vehicle accident? Yes / No If yes, when?_____

Struck your head? Yes / No

Currently I am Experiencing. Please circle all that apply and explain if necessary.

Fatigue
Numbness / Tingling
Constipation
Fever / Chills / Sweats
Muscle Weakness
Diarrhea
Nausea / Vomiting
Dizzy / Lightheadedness
Shortness of Breath
Weight loss / gain
Heartburn / Indigestion
Fainting
Difficulty with balance
Difficulty swallowing
Cough
Falls
Changes in Bowel / Bladder function
Headaches
Circulation changes
Pain in Feet
Difficulty sleeping
Abdominal pain
Malaise

Is your doctor aware of the condition(s) you just indicated? Yes / No

During the past month have you been feeling down, depressed or hopeless? Yes / No

During the past month have you been feeling little interest or pleasure in doing things? Yes / No

Is this something with which you would like help? Yes / Yes but not today / No

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Current Condition

When and how did your symptoms / condition start? Date:_____
_____

Did you have surgery? Yes / No Date:_____What surgery was performed?_____
_____

Please list any special tests performed for this condition (X-rays, MRI, Labs, etc…)_____
_____

May we have access to these tests? Yes / No

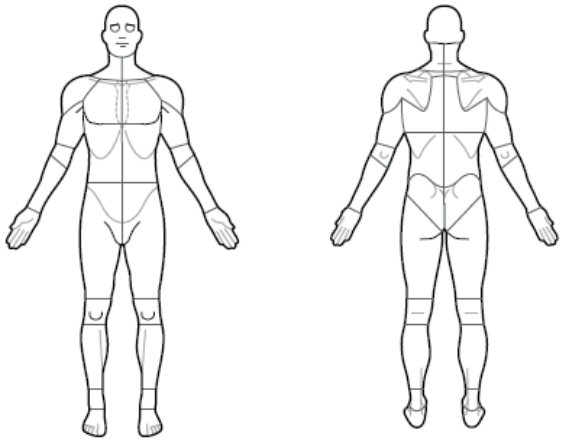
Have you ever had this problem before? Yes / No When?_____ Treatment received:
_____

How long did it take for you to get better? _____

Are you able to sleep? ☐ Fine ☐ Moderate ☐ Only with Medication ☐ Explain_____

Are symptoms getting better, worse or the same?

❑Symptoms come and go
❑Constant
❑Constant but changes with activity



_____

Body Diagram Pain Scale. Mark areas where you feel symptoms on diagram at left:
↓ Shooting / Sharp
○ Dull / Aching
lll Numbness
= Tingling

Pain Scale.

0	1	2	3	4	5	6	7	8	9	10
None	Just noticeable	Mild, in background		Moderate, bothersome		Severe, can't function		Excruciating , ER time		Burning at the stake!!

Current level of pain while filling out this form. _____

The BEST your pain has been during the past 48 hours: _____ The worst pain: _____

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Aggravating Factors	**Alleviating Factors**
❑ Sitting	❑ Sitting
❑ Coughing	❑ Heat / Cold
❑ Walking	❑ Walking
❑ Exercising	❑ Exercise
❑Lying down	❑ Lying down
❑ Other _____	❑ Other _____

When are your symptoms worse: Morning Mid-day Evening After exercise

Please list any medications you are currently on, including vitamins, etc…; and any medications prescribed but not yet taken: _____

Patient Signature: _____ Date: _____

Reviewed and signed by Therapist: _____ Date: _____