PERSONAL MEDICAL HISTORY FORM

Institute of Physical Therapy and Fitness

PATIENT NAME:_____

Height _____ Weight _____

1. Circle/list any medical problems that you currently have or have had:

Allergies	Cancer	Dizziness	High/Low Blood Pressure	Seizures
Arthritis	Change in Bowel/Bladder	Fibromyalgia	Night Pain	Stroke/TIA
Asthma/COPD/Emphysema	Chest Pain/Angina	Head Aches	Numbness/Tingling	Other:
Blood Clots	Diabetes	Heart Disease/Attack	Osteoporosis/Osteopenia	Other:

2. List any operations or surgeries that you have had:

3. Any significant weight gain/loss in the last year? Yes No (+ -)_____lbs

4. Are you under the care of any other medical/health provider or physician? Yes No

If yes, for what condition are you being treated? 1)_____

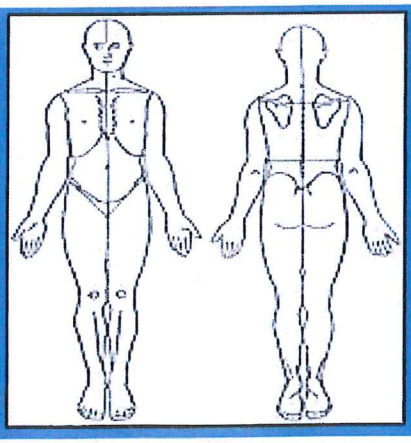
2)_____ 3)_____

5. List any medications you are currently taking:

6. What do you expect to gain/accomplish in receiving physical therapy?

_____

7. Please indicate on the picture to the right where you are experiencing pain:



TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.

Signature:_____ **Date:**_____