PATIENT HEALTH HISTORY

Name____ Age __________ Date of Birth ______________
FIRST NAME MIDDLE INITIAL LAST NAME

Referring Physician ____________________________ Date of Last Appt ____________ Date of Next Appt ___________

Family or Other Physician ______________________ Date of Last Appt ____________ Date of Next Appt ___________

Date of onset of current condition ___________ Have you had surgery for this condition? ___ Y ___ N When? __________

Have you received PHYSICAL or OCCUPATIONAL THERAPY in the past? ___ Y ___ N When? ____________________

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Please list any medications you are taking for this condition or any other condition? ______________________________

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Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
High Blood Pressure	□	□	AIDS or HIV Infection	□	□	Rheumatoid Arthritis	□	□
Heart Attack	□	□	Hepatitis A B C	□	□	Joint Replacement	□	□
Low Blood Pressure	□	□	Heart Disease	□	□	Stomach Disorder/Ulcer	□	□
Rheumatic Fever	□	□	Cardiac Pacemaker	□	□	Thyroid Problem	□	□
Swollen Ankles	□	□	Heart Murmur	□	□	Stroke	□	□
Fractures	□	□	Chest Pain	□	□	Tuberculosis	□	□
Asthma	□	□	Anemia	□	□	Liver Disease	□	□
Epilepsy/Seizures	□	□	Osteoporosis	□	□	Diabetes	□	□
Fibromyalgia	□	□	Emphysema	□	□	High Cholesterol	□	□
Incontinence	□	□	Cancer / Leukemia	□	□	Other - specify: ____________		
Kidney Diseases	□	□	Osteoarthritis	□	□	________________________		

WOMEN: Are you pregnant or think you may be pregnant? ___Yes ___No Are you postmenopausal? ___ Yes ___ No

Please list any surgeries and the approximate dates these occurred.

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Are you allergic to or have you had any reactions to the following?

	Y	**N**		**Y**	**N**
Local Anesthetics (e.g. Novocaine)	□	□	Bee Stings	□	□
Iodine	□	□	Medications	□	□
Latex Rubber	□	□	Please specify: ____________________		