

**LEPRE PHYSICAL THERAPY
PATIENT MEDICAL HISTORY FORM**

Name: _____ ID# _____ DOB: _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY: (please check any condition you have a history of. Items not checked are understood to be negative.)

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Bowel or Bladder Problems |
| <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune disorder |
| <input type="checkbox"/> Abnormal Heart Rate | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Recent and sudden Weight Loss/Gain |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Chronic Lung Problem | <input type="checkbox"/> Thyroid Problem (Hyper or Hypo) |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Chronic Heartburn | <input type="checkbox"/> Diabetes (medication dependent? YES/NO) |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> History of Ulcers | <input type="checkbox"/> Cancer/tumors (where? _____) |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Chronic heartburn/Intestinal upset |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hearing problems |

Other: _____

- | | | | |
|--|-----|----|-------------------------|
| Do you have a history of fractures? | YES | NO | Where? _____ |
| Do you have a history of back/neck pain? | YES | NO | When? _____ |
| Do you have any metal implants? | YES | NO | Where? _____ |
| Do you smoke? | YES | NO | How much per day? _____ |
| Do you exercise regularly? | YES | NO | How often? _____ |
| Do you have any known allergies? | YES | NO | Please list _____ |
| Are you allergic to latex? | YES | NO | |
| Are you pregnant or suspect pregnancy? | YES | NO | |

MEDICATIONS: Please check if you are taking any of the following (Please list name of medications)

- | | | |
|--|--|---|
| <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> Heart Medication | <input type="checkbox"/> Anti-coagulants (blood thinners) |
| _____ | _____ | _____ |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Pain Killers | <input type="checkbox"/> Diabetes Medication (i.e. Insulin) |
| _____ | _____ | _____ |
| <input type="checkbox"/> Steroids (Cortisone) | <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Other Medications |
| _____ | _____ | _____ |

SURGERIES: Please list all surgeries, including date:

DIAGNOSTIC TESTS: Please check test(s) for current problem only.

- () X-rays () CT scan () MRI () Bone Scan () EMG () Bone Density
() Blood Chemistry () Ultrasound () Other (please specify) _____

**LEPRE PHYSICAL THERAPY
PATIENT MEDICAL HISTORY FORM**

Have you seen anyone else for your current problem?

()Physician/MD ()Chiropractor ()Podiatrist ()Orthopedic Surgeon ()Dentist
()Neurologist/Neurosurgeon ()Osteopath/DO ()Physical Therapist Date: _____

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities?	YES	NO
Do you have any weakness in your arms or legs?	YES	NO
Do you have any coordination or balance problems?	YES	NO
Do you have difficulty walking?	YES	NO
Do you experience dizziness or vertigo with a change in position?	YES	NO
Have you experienced headaches as a result of your condition?	YES	NO
Have you had this problem before?	YES	NO

CHIEF COMPLAINT/ CURRENT CONDITIONS: Please describe: _____

Please rate your pain in this scale of 0-10.

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain imaginable

I believe all information to be true and complete: Signature _____ Date: _____

Physical Therapist Signature

Date