PAST MEDICAL HISTORY FORM

Patient Name: ______________________________ Today's Date: ______________________________

Date of Injury: ______________________________ Have you ever had these symptoms before? YES / NO

Cause of Injury: ______________________________ Have you had a related surgery? YES / NO

Primary Care Physician: ______________________ Referring Physician (if different from PCP): ______________

Are you currently using Home Health Services? YES / NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes / No			Yes / No	
Diabetes	Y	N	Allergies to Aspirin	Y	N
Chest Pain/Angina	Y	N	Allergies to Heat	Y	N
High Blood Pressure	Y	N	Poor tolerance to cold	Y	N
Heart Disease	Y	N	Other Allergies	Y	N
Heart Attack	Y	N	Hernia	Y	N
Heart Palpations	Y	N	Seizures	Y	N
Pacemaker	Y	N	Metal Implants	Y	N
Headaches	Y	N	Dizziness/Fainting	Y	N
Kidney Problems	Y	N	Recent Fractures	Y	N
Are you Pregnant?	Y	N	Surgeries	Y	N
Cancer	Y	N	Skin Abnormalities	Y	N
Osteoporosis	Y	N	Sexual Dysfunction	Y	N
Bowel/Bladder Abnormalities	Y	N	Nausea/Vomiting	Y	N
Urine Leakage	Y	N	Ringing in your Ears	Y	N
Asthma/Breathing Difficulties	Y	N	Rheumatoid Arthritis	Y	N
Liver/Gallbladder Problems	Y	N	Special Diet Guidelines	Y	N
Smoking	Y	N	Hypoglycemia	Y	N
Infectious Disease	Y	N	Stroke/CVA	Y	N

Please describe any conditions from above.

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Please list current medications you are taking.

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