Carolina Physical Therapy and Sports Medicine, Inc.

MEDICAL HISTORY FORM

Today's date: _____

Date of injury or onset: _____

Referring physician's name: _____

Primary care physician's name: _____

Are you presently working? [ ]Yes [ ]No

Cause of injury or onset: _____

Date of next MD appt: _____

Do you currently have any flutype symptoms (i.e. fever, coughing)? [ ]Yes [ ]No

If yes, what symptoms: _____

Do you have any open cuts, lesions or wounds? [ ]Yes [ ]No

If yes, where: _____

Have you fallen in the past year? [ ]Yes [ ]No

If yes, how many times: _____

If yes to falling, did you sustain an injury as result of the fall? [ ]Yes [ ]No

What is your reason for attending therapy: _____

_____

_____

Because of your problem, what specific activities are you having difficulty with?

1. _____
2. _____
3. _____

What are your personal goals/outcomes you hope to achieve from therapy?

1. _____
2. _____
3. _____

Describe your general health: [ ]Excellent [ ]Good [ ]Fair [ ]Poor

Do you use tobacco? (circle one)? [ ]Yes [ ]No

If yes, how much? _____

Wear glasses/ contacts)? [ ]Yes [ ]No

Have you recently been hospitalized or had surgery)? [ ]Yes [ ]No

If yes, when _____

And why _____

Have you had prior physicauoccupational therapy for this condition? (circle one)? [ ]Yes [ ]No

What was done? /what were the results?: _____

Have you had prior physical/occupational therapy this calendar year? [ ]Yes [ ]No

Was it received at: [ ]Hospital [ ]Outpatient Center [ ]Home Health

For how long? _____

Current medications: _____

_____

_____

Carolina Physical Therapy
MEDICAL HISTORY FORM

Allergies:

Medication/Substance	Reaction	Other ,reaction

Are you allergic to latex? [ ]Yes [ ]No
If yes what is the reaction _____
Are you allergic to dexamethasone? [ ]Yes [ ]No
If yes what is the reaction? _____
Do you currently have or have a history of any of the following conditions? (check all that apply)

[ ] Anemia
[ ] Arthritis
[ ] Asthma [ ]Controlled [ ]Uncontrolled
[ ] Blood Thinners (Anticoagulants}
[ ] Cancer
[ ] Cardiovascular Problems
[ ] COPD [ ]Controlled [ ]Uncontrolled
[ ] Currently Pregnant
[ ] Depression
[ ] Diabetes [ ]Controlled [ ]Uncontrolled
[ ] Dizziness/Fainting
[ ] Fractures
[ ] Headaches
[ ] Hepatitis/HIV
[ ] High Blood Pressure [ ]Controlled [ ]Uncontrolled
[ ] Holter Monitor - Currently Wearing? [ ]Yes [ ]No
[ ] Kidney Problems
[ ] Low Blood Pressure
[ ] MRSA (Methicillin Resistant Staphylococcus Aureus)
[ ] Osteoporosis
[ ] Pacemaker
[ ] Respiratory Problems
[ ] Seizures [ ]Controlled [ ]Uncontrolled
[ ] Thyroid Problems
[ ] Other

If checked any above, explain: _____
_____
_____
_____
Other medical problems: _____
_____
_____
_____
Signature of patient _____
Reviewed by therapist: _____ Date _____

This form must be completed in its entirety and must be provided Caroline Physical Therapy prior to initiation of therapy services.