AC Physical Therapy

PAST MEDICAL HISTORY INFORMATION

INDICATE IF YOU CURRENTLY OR IN THE PAST HAVE HAD ANY OF THE FOLLOWING:

DIABETES	_____	ALLERGIES	_____	URGE INCONTINENCE	_____
CANCER	_____	HEADACHES	_____	STRESS INCONTINENCE	_____
HEART DISEASE	_____	SEIZURES	_____	DIZZINESS, VERTIGO	_____
HEART ATTACK	_____	NUMBNESS	_____	DERMATITIS	_____
PACEMAKER	_____	ARTHRITIS	_____	HERNIA	_____
HIGH BLOOD PRESSURE	_____	FIBROMYALGIA	_____	IMPLANTS	_____
BLOOD DISORDERS	_____	OSTEOPOROSIS	_____	NERVOUS SYSTEM DISORDERS	_____
KIDNEY PROBLEMS	_____	OSTEOPENIA	_____	MENTAL OR OTHER DISORDERS	_____
STROKE	_____	MIGRANES	_____	SPINE PAIN	_____
VISION CHANGES	_____	HEAD INJURY	_____	PANIC ATTACKS/ANXIETY	_____
HISTORY OF MRSA/VME	_____				

DO YOU SMOKE? Yes _____ No _____ (Female patients only) ARE YOU PREGNANT? Yes _____ No _____

RECENT SURGERY? Yes _____ No _____ If yes, explain _____

LIST ANY DRUG OR FOOD ALLERGIES : _____

WE ARE REQUIRED TO HAVE ON FILE A COMPLETE LIST OF ALL MEDICATION YOU ARE PRESENTLY TAKING, INCLUDING OVER THE COUNTER, HERBALS, AND VITAMIN/MINERAL/DIETARY (NUTRITIONAL) SUPPLEMENTS (you may use the back of this form if you need additional space)

Medication_____Dosage_____Frequency_____Route_____
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Medication_____Dosage_____Frequency_____Route_____

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE,

SIGNED: DATE: