peterson2 PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Patient Name _____ Date_____/_____/_____

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

Condition	Yes ✔	Date Diagnosed	Current Status
Pacemaker			
Arthritis			
Asthma/Breathing Disorder			
Allergies/Hay Fever			
Back Pain/Injury			
bleeding Disorder			
Cancer			
Diabetes			
Heart Attack/Problems			
Head Injury			
Hearing/Vision Problems			
High Blood Pressure			
Kidney/Bladder Trouble			
Osteoporosis			
Stroke			
Ulcer/Stomach			
Bowel Problems			
Currently Pregnant?			
Implants (Location _____)			
Total Joint Replacement			

Other:_____

Current Medications:

_____ _____

_____ _____

_____ _____

I verify the above information is correct and will be used only by the Physical Therapist and his staff to ensure my health and safety. Patient Initials_____

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