Physical Therapy of Central Virginia

PAST MEDICAL HISTORY FORM

Patient Name_____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

OTHER CONDITIONS	YES	NO
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Seizures	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other:_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

KEY QUESTIONS ABOUT YOUR CONDITION

1. What is your **MAIN** complaint? _____

_____

_____

2. How did your pain start? _____

_____

3. Please mark your level of pain with an X along the following lines

What is your pain at rest?

0 ——————————— 10

What is your pain with activity?

0 ——————————— 10

4. When did your problem/injury occur or become worse? ___/___/____

GENERAL HEALTH

5. Activity level: ☐ Low ☐ Medium ☐ High

6. Are you having trouble sleeping ☐ Yes ☐ No

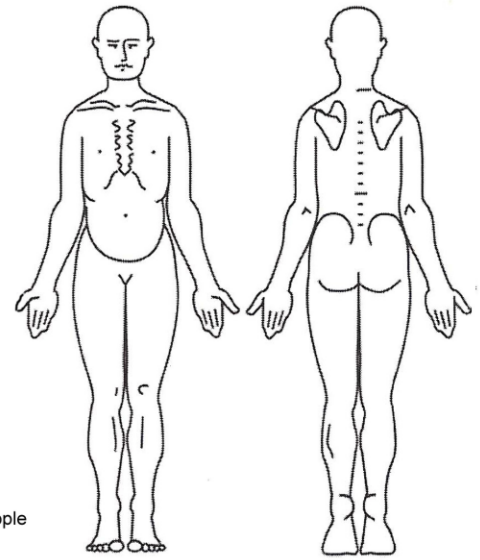
Normal hours of sleep _____hours

Current hours of sleep _____hours

7. Are you experiencing or have any of the following:

☐ Apprehension
☐ Crying episodes
☐ Low energy or frequent fatigue
☐ Avoiding or uncomfortable with people
☐ Weight loss (10 lbs or more)
☐ Shortness of breath

Darken the areas on the body where you are having problems.



_____ _____

Signature of Patient, Parent, Guardian, Personal Representative — Date