FREDERICKSBURG ORTHOPAEDIC ASSOCIATES, P.C.
PHYSICAL THERAPY INSTITUTE

PERSONAL MEDICAL HISTORY FORM

After completing this form, print and sign at the bottom; and, provide to the receptionist when you check in.

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Check all that apply and explain the following medical problems that you have had:

☐ AIDS / HIV	☐ Drug Abuse	☐ Liver Disease
☐ Allergies	☐ Emphysema	☐ Motor Vehicle Accident
☐ Anemia	☐ Fainting	☐ Psychiatric Treatment
☐ Arthritis	☐ Fractures	☐ Rheumatic Heart Disease
☐ Asthma	☐ Glaucoma	☐ Seizures
☐ Back Trouble	☐ Heart Disease	☐ Shortness of Breath
☐ Bronchitis	☐ Heart Attack	☐ Sinusitis
☐ Cancer	☐ Heart Murmur	☐ Stomach Ulcers
☐ Chest Pain	☐ Hepatitis	☐ Stroke
☐ Congenital Heart Defect	☐ Herpes	☐ Swelling of Hands / Feet
☐ Convulsions	☐ High Blood Pressure	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Bleeding Disease	☐ Osteoporosis	☐ Osteopenia

2. List any operation or surgery that you have had:

3. Reasons for being referred to Physical Therapy:

4. List any medication you are currently taking:

5. List any allergies and describe any drug reactions:

6. Please check any of the following you may have / wear:

☐ Glasses ☐ Contacts ☐ Dentures ☐ Pacemaker ☐ Metal Foreign Object Implant

7. Are you pregnant? ☐ Yes ☐ No

8. Any significant weight gain / loss in the last year? ☐ Yes ☐ No (±) _____lbs

9. Are you under the care of any other medical/health provider or physician? ☐ Yes ☐ No
   If Yes, for what condition are you being treated? _____

10. What do you expect to gain/accomplish in receiving physical therapy?

_____

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.

Signature:_____ Date:_____