## Medical History

## Sports & More Physical Therapy, Inc.

**Patient Name**_____ **Date** _____

**Existing or Relevant Previous Conditions:**

**Describe any other conditions**

| | | | | | |
|---|---|---|---|---|---|
| Allergies | ☐ Yes ☐ No | Dizzy Spells | ☐ Yes ☐ No | MRSA | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Emphysema/Bronchitis | ☐ Yes ☐ No | Multiple Sclerosis | ☐ Yes ☐ No |
| Anxiety | ☐ Yes ☐ No | Fibromyalgia | ☐ Yes ☐ No | Muscular Disease | ☐ Yes ☐ No |
| Arthritis | ☐ Yes ☐ No | Fractures | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Gallbladder Problems | ☐ Yes ☐ No | Parkinsons | ☐ Yes ☐ No |
| Autoimmune Disorder | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Rheumatoid Arthritis | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Hearing Impairment | ☐ Yes ☐ No | Seizures | ☐ Yes ☐ No |
| Cardiac Conditions | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No | Smoking | ☐ Yes ☐ No |
| Cardiac Pacemaker | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No | Speech Problems | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | High/Low Blood Pressure | ☐ Yes ☐ No | Strokes | ☐ Yes ☐ No |
| Circulation Problems | ☐ Yes ☐ No | HIV/AIDS | ☐ Yes ☐ No | Thyroid Disease | ☐ Yes ☐ No |
| Currently Pregnant | ☐ Yes ☐ No | Incontinence | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Depression | ☐ Yes ☐ No | Kidney Problems | ☐ Yes ☐ No | Vision Problems | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Metal Implants | ☐ Yes ☐ No | | |

**If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions**

**Fall History**

| |
|---|
| Injury as result of a fall in the past year? ☐ Yes ☐ No |
| Two or more falls in the last year? ☐ Yes ☐ No |

**Surgical History**

Body Region:_____ Surgery Type:_____ Date:____/____/____

Body Region:_____ Surgery Type:_____ Date:____/____/____

Body Region:_____ Surgery Type:_____ Date:____/____/____

**Current Medications OR Medication List provided** _____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking: _____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking: _____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking: _____

_____ **Currently not taking any medications**

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A**dditional medical information/history since last seen:** **Today's Date** _____

**Fall History**

| |
|---|
| Injury as result of a fall in the past year? ☐ Yes ☐ No |
| Two or more falls in the last year ☐ Yes ☐ No |

**Surgical History – Since last episode of care:**

Body Region:_____Surgery Type:_____Date:_____/_____/_____

Body Region:_____Surgery Type:_____Date:_____/_____/_____

Body Region:_____Surgery Type:_____Date:_____/_____/_____

**Current Medications or Medication List Provided: _____ Currently not taking any Medications _____**

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Other:

_____

_____

_____

A**dditional medical information/history since last seen:** **Today's Date** _____

**Fall History**

| |
|---|
| Injury as result of a fall in the past year? ☐ Yes ☐ No |
| Two or more falls in the last year? ☐ Yes ☐ No |

**Surgical History – Since last episode of care:**

Body Region:_____Surgery Type:_____Date:_____/_____/_____

Body Region:_____Surgery Type:_____Date:_____/_____/_____

Body Region:_____Surgery Type:_____Date:_____/_____/_____

**Current Medications OR Medication List provided _____Currently not taking any medications _____**

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Other:

_____

_____