

ASHLAND PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO	OTHER CONDITIONS	YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS	YES	NO	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____		

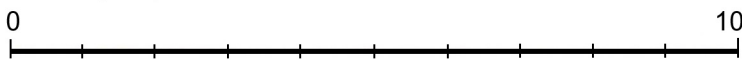
EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor		
What types of exercise do you perform? : _____			

KEY QUESTIONS ABOUT YOUR CONDITION

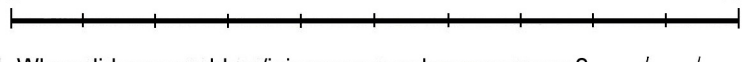
1. What is your **MAIN** complaint? _____

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?



What is your pain with activity?



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

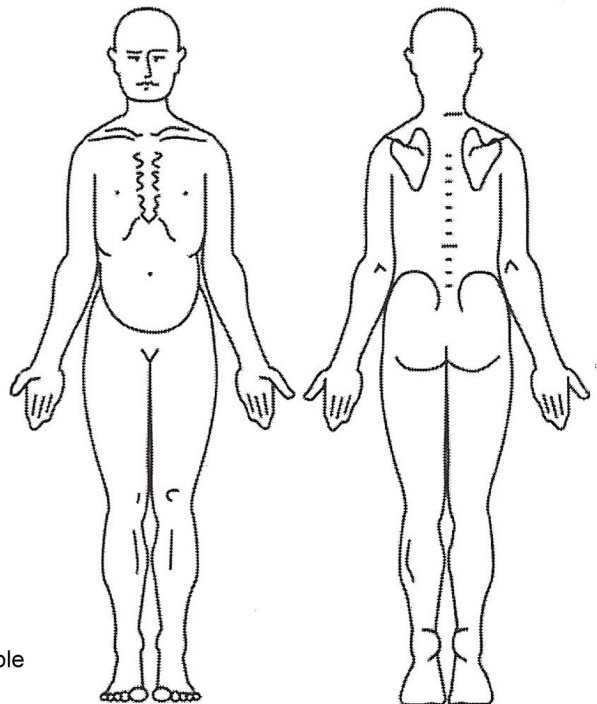
Normal hours of sleep _____ hours

Current hours of sleep _____ hours

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

- | | |
|---|--|
| <input type="checkbox"/> Apprehension | <input type="checkbox"/> Avoiding or uncomfortable with people |
| <input type="checkbox"/> Crying episodes | <input type="checkbox"/> Weight loss (10 lbs or more) |
| <input type="checkbox"/> Low energy or frequent fatigue | <input type="checkbox"/> Shortness of breath |

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



Signature of Patient, Parent, Guardian, Personal Representative _____

Date _____