RICHMOND PHYSICAL THERAPY

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	☐	☐
Latex Allergy	☐	☐

Other ____________________

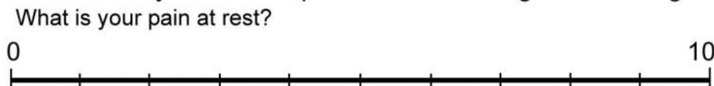
EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ______
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ______
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ______
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : ____________________

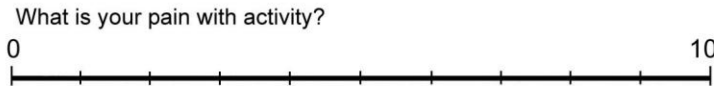
KEY QUESTIONS ABOUT YOUR CONDITION

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?



What is your pain with activity?

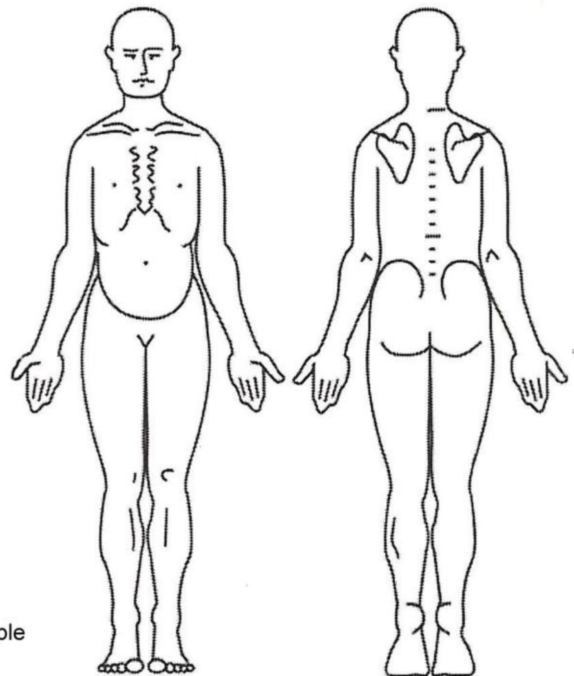


4. When did your problem/injury occur or become worse? ___/___/____

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:
   - ☐ 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.



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Signature of Patient, Parent, Guardian, Personal Representative

____
Date

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