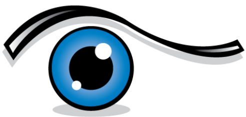

Patient Name ____________ Account # ________ Date ________

Medical History

List Current Medications: ____

____

Known Medication Allergies: ____

Have you ever had or are you currently being treated for any of the following conditions?	Yes	No	If Yes, circle condition or explain
Previous Surgeries			
Ear, Nose or Throat (hearing loss, sinus, any other ENT problems)			
Cardiovascular (heart problems, high blood pressure, cholesterol, chest pain)			
Respiratory (asthma, shortness of breath, lung problems)			
GI or GU (heartburn, diarrhea, vomiting, abdominal pain, kidney, urinary infection)			
Musculoskeletal (arthritis, muscle or joint pain and swelling)			
Skin (rash, cancer)			
Neurologic (stroke, headaches, numbness, weakness, paralysis)			
Psychiatric (anxiety, depression, developmentally delayed)			
Endocrine (diabetes, thyroid problems)			
Hematologic (blood disorders, anemia, leukemia, HIV+, AIDS, hepatitis)			
Allergic or Immunologic (allergies, hay fever or any other)			
Other			

Family and Social History: Is there a history of any of the following conditions in your family?

☐ Diabetes Whom:_____________ ☐ High Blood Pressure Whom: _____________

Do you smoke? Yes No How much?_______ **Did you ever smoke?** Yes No When did you quit? __________

Do you live alone? Yes No **Pregnant And/Or Nursing ?** Yes No

Height ______ **Weight** _____ **Have you had a fall in the last year**? Yes No

Have you had Pneumonia Vaccine? Yes No **Have you had Flu Vaccine this year ?** Yes No

_______________________________ ____________________

Patient Signature **Date**

****

Any Changes? Yes No PT Initials ________ Date:_______ Employee Initials _______

Any Changes? Yes No PT Initials ________ Date:_______ Employee Initials _______