KATHY BRAUN, PT, ATC
PHYSICAL THERAPIST

MEDICAL HISTORY AND INFORMATION

Name: _____ **Occupation**: _____ **Age**: _____

Are you latex sensitive? YES☐ NO☐

Do you have any other allergies? YES☐ NO☐ (List) _____

Do you smoke cigarettes? YES☐ NO☐

FOR WOMEN: Are you currently pregnant or do you think you might be pregnant? YES☐ NO☐

Are you under the care of any of the following? (Please Check):

☐ **Internal Medicine** ☐ **Physiatrist** ☐ **Neurologist** ☐ **Osteopath** ☐ **Orthopedist**
☐ **Physical Therapist** ☐ **Dentist** ☐ **Chiropractor** ☐ **Psychiatrist/Psychologist**

Have you ever been diagnosed with the any of the following conditions?

YES☐ NO☐ **Cancer**	YES☐ NO☐ **Heart Problems**	YES☐ NO☐ **High Blood Pressure**
YES☐ NO☐ **Asthma**	YES☐ NO☐ **Diabetes**	YES☐ NO☐ **Circulation Problems**
YES☐ NO☐ **Hepatitis**	YES☐ NO☐ **Thyroid Problems**	YES☐ NO☐ **Emphysema/Bronchitis**
YES☐ NO☐ **Stroke**	YES☐ NO☐ **Multiple Sclerosis**	YES☐ NO☐ **Rheumatoid Arthritis**
YES☐ NO☐ **Tuberculosis**	YES☐ NO☐ **Kidney Disease**	YES☐ NO☐ **Other Arthritic Problems**
YES☐ NO☐ **Anemia**	YES☐ NO☐ **Pacemaker**	YES☐ NO☐ **Epilepsy/Seizures**
YES☐ NO☐ **Dizziness**	YES☐ NO☐ **Headaches**	YES☐ NO☐ **Depression/Anxiety**
YES☐ NO☐ **Herpes**	YES☐ NO☐ **HIV/AIDS**	YES☐ NO☐ **Osteoporosis**

Please list any surgeries and/or hospitalizations along with the date and reasons for each: _____

_____

Please list any significant injuries for which you have been treated (fractures, sprains, dislocations, etc.) with the approximate date of injury: _____

_____

Please list any **OVER THE COUNTER MEDICATIONS** you have taken THIS WEEK

1. _____ 2. _____ 3. _____

Please list any **PRESCRIPTION MEDICATIONS** you are CURRENTLY TAKING

1. _____ 2. _____ 3. _____

Have you recently noticed?

YES☐ NO☐ **Weight Loss/Gain**	YES☐ NO☐ **Weakness**	YES☐ NO☐ **Fatigue**
YES☐ NO☐ **Fevers/Chills/Sweats**	YES☐ NO☐ **Nausea/Vomiting**	YES☐ NO☐ **Numbness/Tingling**

Please describe your chief problem: _____

_____

_____

_____

Patient Signature: _____ **Therapist Signature**: _____

Date: _____ **Date**: _____