

# Canyon Physical Therapy & Aquatic Rehabilitation

## PATIENT MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Have you ever been diagnosed with any of the following:

Condition	Yes	No	Current Status
Arthritis	_____	_____	_____
Asthma/Breathing Disorder	_____	_____	_____
Allergies	_____	_____	_____
Back Pain/Injury	_____	_____	_____
Bleeding Disorder/Blood Clots	_____	_____	_____
Cancer	_____	_____	_____
Circulation Problems	_____	_____	_____
Diabetes	_____	_____	_____
Dizzy Spells	_____	_____	_____
Fractures	_____	_____	_____
Heart Attack/Cardiac Conditions	_____	_____	_____
Head Injury	_____	_____	_____
Hearing/Vision Problems	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney/Bladder Trouble	_____	_____	_____
Liver Problems	_____	_____	_____
Nervous Disorder	_____	_____	_____
Osteoporosis	_____	_____	_____
Pacemaker	_____	_____	_____
Seizures	_____	_____	_____
Sensitivity to Heat/Cold	_____	_____	_____
Speech Problems	_____	_____	_____
Stroke	_____	_____	_____
Ulcer/Stomach/Bowel Problems	_____	_____	_____
Currently Pregnant	_____	_____	_____
Implants (location: _____)	_____	_____	_____
Total joint replacements	_____	_____	_____
Any recent/unexplained weight loss	_____	_____	_____

Any other illnesses? Please explain: \_\_\_\_\_

**Generally my health is:**                      EXCELLENT                      GOOD                      FAIR                      POOR

Have you recently been ill? (last 6 months) \_\_\_\_\_

Please indicate illness: \_\_\_\_\_

Have you been hospitalized? (last 12 months) \_\_\_\_\_

Please indicate reason \_\_\_\_\_

Have you had any surgery recently? (last 12 months) \_\_\_\_\_

Please indicate type of surgery \_\_\_\_\_

Have you had a fall in the last 12 months? \_\_\_\_\_ If Yes, how many times? \_\_\_\_\_ Describe each fall and any related injuries: \_\_\_\_\_

I verify that the above information is correct and will be used only by the P.T. to ensure my health and safety. I also agree to inform the P.T. should any changes occur as far as my medical history.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Office Use: PT Initials