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 ____