Breeze Physical Therapy and Wellness LLC

Past Medical History Form

Name: ___________________________ Date _________ Referring Dr: ________________

Are you presently working? Yes ____ No____

How many days per week do you exercise? Yes ____ No____

Describe the exercise: ____

Check which one applies to your current condition:

( ) Motor vehicle accident ( ) Work-Related injury ( ) Injury related to falling

( ) Recurrence of previous injury ( ) Injury related to lifting ( ) Cause unknown

( ) Athletic/Recreational injury ( ) Other:____

Have you ever had these symptoms before? Yes ____ No____

Have you had a related surgery? Yes ____ No____

Do you have or have had any of the following:

Pacemaker Yes__ No__
Chest Pain/Angina Yes__ No__
Heart Disease/Attack Yes__ No__
High Blood Pressure Yes__ No__
Cancer/Tumor Yes__ No__
Kidney Problems Yes__ No__
Stroke Yes__ No__
Bowel/Bladder Abnormalities Yes__ No__
Pregnancy Yes__ No__
Asthma/Breathing Difficulties Yes__ No__
Liver/Gallbladder Problems Yes__ No__
Hypoglycemia /Diabetes Yes__ No__
Osteoarthritis/Rheumatoid Yes__ No__
Rheumatic Arthritis Yes__ No__
Sensitivity to heat/cold Yes__ No__

Unusual Headache Yes__ No__
Osteoporosis Yes__ No__
Hernia Yes__ No__
Seizures Yes__ No__
Metal Implants Yes__ No__
Dizziness/Fainting Yes__ No__
Fracture Yes__ No__
Surgeries Yes__ No__
Skin Abnormalities Yes__ No__
Nausea/Vomiting Yes__ No__
Ringing in ears Yes__ No__
Loss in Balance Yes__ No__
Difficulty Walking Yes__ No__
Smoking Yes__ No__
Other_______________ Yes No

If you answered yes to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

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Do you have any allergies to medication(s) or latex? Yes ____ No____
If yes, please list your allergies:
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Are you presently taking any medications? Yes ____ No____
If yes, please list medications on the below:

Medication list – *If you have a list on hand a copy can be made in the office*

Medication	Dosage	How Often