Past Medical History

Name: _____ **Date:** _____ **Age:** _____

Please include information that gives our physical therapists a picture of your past medical health.
A safe & successful rehabilitation is our goal.

(if "Yes" please specify)

ڤ No ڤ Yes **Allergies (Latex, Tape)** _____
ڤ No ڤ Yes **Fractures** _____
ڤ No ڤ Yes **Other Injuries (joint, muscle)** _____
ڤ No ڤ Yes **Back Condition** _____
ڤ No ڤ Yes **Arthritis** _____
ڤ No ڤ Yes **Neurological Condition** _____
ڤ No ڤ Yes **Kidney Condition** _____
ڤ No ڤ Yes **Stomach/Intestinal Condition** _____
ڤ No ڤ Yes **Heart Condition** _____
ڤ No ڤ Yes **Blood Pressure (high or low)** _____
ڤ No ڤ Yes **High Cholesterol** _____
ڤ No ڤ Yes **Skin Condition** _____
ڤ No ڤ Yes **Diabetes (Type I or Type II)**_____
ڤ No ڤ Yes **Cancer** _____
ڤ No ڤ Yes **Infections** _____
ڤ No ڤ Yes **COVID-19** _____
If Yes, do you continue to experience any of the following long term symptoms?
ڤ No ڤ Yes **Chronic Fatigue**_____
ڤ No ڤ Yes **Shortness of Breath** _____
ڤ No ڤ Yes **Difficulty recovering from activities**_____
ڤ No ڤ Yes **Weakness**_____
ڤ No ڤ Yes **Feelings of increased heart rate**_____

Other Medical Conditions / Surgeries:

_____

_____

_____

_____