Louisville Physical Therapy, LLC
PATIENT MEDICAL HISTORY

Patient Name _____ PTOS #: _____

Welcome to Louisville Physical Therapy. The following is a brief medical history that we ask you to fill out so we can better understand your condition and any possible contributing factors. Please feel free to ask questions at any time throughout your treatment progress. We also want to emphasize how important it is that you keep your scheduled appointments, each treatment is a significant part of your progress.

Do you or have you had any of the following:

Diabetes	Yes	No	Cardiac Problems	Yes	No
If Yes, Insulin Dependent?	Yes	No	Pacemaker	Yes	No
Headaches	Yes	No	High Blood Pressure	Yes	No
Orthopaedic Problems	Yes	No	Balance Problems	Yes	No
Cancer	Yes	No	Lung Disease	Yes	No
Stroke	Yes	No	Epilepsy	Yes	No

If yes, to any of the above, please explain and given approximate dates:

_____

_____

_____

Any other known medical conditions that your therapist should be aware of: _____

_____

Have you recently had any of the following?

Shortness of breath	Yes	No	Fainting with exercise	Yes	No
Chest pain with exertion	Yes	No	Numbness or Tingling	Yes	No
Dizziness	Yes	No	Painful or Swollen Joints	Yes	No

Are you currently taking any prescription or non-prescription medications? Yes No

Please check any medications that you are taking?

( ) Anti-inflammatories ( ) Pain Medication

( ) Muscle Relaxants ( ) Other: _____

Current medications:

_____

_____

_____

_____

Are you aware of your diagnosis? ( ) Yes ( ) No

What are your goals for this rehabilitation program? _____

_____

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____