Orthopedic & Sports Physical Therapy

Pertinent Medical History

Patient Name: _____ **Date:** _____

Circle "Y" for YES or "N" for NO for all of the following that apply to your current and/or past medical history:

Heart Disease

Y/N Congestive Heart Failure (CHF)
Y/N High Blood Pressure/Hypertension
Y/N Heart Attack (Myocardial Infarction) (MI)
Y/N Coronary Artery Bypass Graft (CABG)
Y/N Valvular Disease
Y/N Atherosclerotic Disease (CAD)
Y/N Arrhythmia
Y/N Stents
Y/N Angioplasty
Y/N Angina

Lung Disease

Y/N Emphysema Y/N Asthma Y/N Recent Pneumonia Y/N Chronic Obstructive Pulmonary Disease (COPD)

Vascular Disease

Y/N Peripheral Arterial Disease
Y/N Acquired Respiratory Distress Syndrome (ARDS)
Y/N Taking Blood Pressure Meds
Y/N Chronic Bronchitis
Y/N Stroke/TIA
Y/N Diabetes

General Medical Conditions

Y/N Arthritis (rheumatoid/osteoarthritis)
Y/N Anxiety or Panic Disorders
Y/N Neurological Disease (such as MS or Parkinson's)
Y/N Kidney, Bladder, Prostrate or Urination Problems
Y/N Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
Y/N Hearing Impairment very hard of hearing, even with hearing aids
Y/N Visual Impairment (such as cataracts, glaucoma, macular degeneration)
Y/N Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
Y/N Prosthesis/Implants
Y/N Sleep Dysfunction
Y/N Previous Accidents
Y/N Incontinence
Y/N Headaches
Y/N Allergies
Y/N Cancer
Y/N Depression
Y/N Osteoporosis
Y/N Hepatitis/AIDS

Women Only: Are you pregnant? ____ Yes ____No

Please list, if any, surgeries, broken bones, current medications, or any other medical conditions below:

Surgeries:

_____

_____

Broken Bones:

_____

Current Medications:

_____

_____

Any Other Medical Conditions:

_____

_____

_____ _____

Patient Signature **Therapist Signature**