Rehab Carolina
Excellence in Physical Therapy

MEDICAL HISTORY

Name: **Date:**

Please check the following conditions that you are currently diagnosed with / receiving care or treatment for:

Anxiety or Panic Disorders	☐
Arthritis	☐
Asthma	☐
Bleeding disorders	☐
Blood clot/DVT	☐
Bowel/Bladder Abnormalities	☐
Cancer	☐
Chest pain	☐
Chronic Obstructive Pulmonary Disease (COPD)	☐
Chronic pain/fibromyalgia	☐
Circulation problems/vascular disease	☐
Congestive Heart Failure	☐
Depression	☐
Diabetes	☐
Difficulty swallowing	☐
Dizzy or Fainting Spells	☐
Emphysema	☐
Epilepsy or Seizure Disorders	☐
Fever	☐
Headaches/Migraines	☐
Head injury	☐
Hearing impairment	☐
Heart condition	☐
Hepatitis A, B, or C	☐
Hernia	☐

High Blood Pressure	☐
HIV/AIDS	☐
Hypoglycemia	☐
Infection	☐
Immunosuppressant Conditions	☐
Kidney Problems	☐
Liver/Gallbladder disease	☐
Metal implants	☐
Multiple Sclerosis	☐
Nausea/Vomiting	☐
Obesity	☐
Osteoporosis	☐
Pacemaker	☐
Parkinson's disease	☐
Peripheral neuropathy	☐
Pregnancy	☐
Ringing in your ears	☐
Sexual Dysfunction	☐
Skin abnormalities	☐
Smoking	☐
Stroke or TIA	☐
Tuberculosis	☐
Unexplained weight loss	☐
Visual impairment	☐

Please list any allergies that you have: _____

_____

Please list any surgical history (orthopedic and otherwise): _____

_____

_____

Is the injury you are here for today related to?
(Check if applicable)

Work	☐
Car Accident	☐
Other Liability/Potential Lawsuit	☐
Not Applicable	☐

Race/Ethnicity (Please check one):

Caucasain (White)	☐
Hispanic or Latino origin	☐
Eskimo/Inuit	☐
African American	☐
Asian	☐
Native American	☐
Other	☐
Declined	☐

Do you have a Primary Care Physician/Family Doctor? Circle one:

YES or NO

If yes, have you had an appointment with him/her in the last 12 months? Circle one:

YES or NO

If yes, please list your Primary Care Physician/Family Doctor:

_____

(name) (phone number)

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MEDICATION LIST

Please list ALL medications (including prescription, over-the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

If you already have a medication list printed, you may bring to clinic for us to make a copy as well.

Medication	Dosage	Frequency	Route of Administration