LINDEN OAKS PHYSICAL THERAPY
Medical History Form

Name:_____ DOB:_____ Date:_____

Please check all that apply:

___ AIDS/HIV
___ Amputation
___ Anemia
___ Anxiety
___ Artificial Heart Valve
___ Artificial Joints
___ Asthma
___ Bleeding Disorder
___ Blood Clots/Clotting Disorder
___ Bypass Surgery
___ Cancer
___ Coronary Artery Disease
___ Congestive Heart Failure
___ Contact Dermatitis
___ COPD
___ CVA (Stroke)
___ Dementia
___ Depression
___ Diabetes Mellitus
___ Emphysema
___ Epilepsy or Seizures
___ Fractures
___ Glaucoma or other Eye Disorders
___ GI Disease
___ Headaches/Migraines
___ Head Injuries
___ Hearing Loss
___ Heart Disease
___ History of Heart Attack
___ High Blood Pressure
___ Kidney Disease
___ Liver Disease
___ Lymphedema
___ Multiple Sclerosis
___ Orthotics/Prosthesis
___ Osteoarthritis
___ Osteopenia
___ Osteoporosis
___ Pacemaker
___ Parkinson's Disease
___ Peripheral Vascular Disease
___ Pregnancy (current)
___ Rheumatoid Arthritis
___ Recurrent Pneumonia
___ Smoker
___ STDs
___ Substance Abuse
___ TIA(s)
___ Thyroid Disease

Other Medical Problems:_____

_____

Surgical History:

Procedure	Date

Medications:

Name	Used For	Dosage

Allergies:

Type	Reaction
Latex ☐ YES ☐ NO	

Exercise History:

___ Lack of exercise

___ Exercising Regularly

- Moderate Exercising (walking briskly, water aerobics, etc.)
  - ___ Less than 3 times per week
  - ___ 3 or more times per week
- Strenuous Exercising (running, swimming laps, etc.)
  - ___ Less than 3 times per week
  - ___ 3 or more times per week

Do you speak a language other than English to communicate? _____

Do you use sign language to communicate: _____

Do you have any cultural or religious beliefs that would impact your care? If yes, please list:

_____

What is your preferred style of learning? ☐ Written ☐ Visual ☐ Learn by Listening

Signature: _____ Date: _____