PAST MEDICAL HISTORY FORM

Patient Name: ____________________________________
Today's Date: ____________________
Date of Injury/Onset:_____________________

Core Balance
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Are you presently working? ☐ Yes ☐ No

Date of next physician's visit: ______________ **Who referred you to PT?**___________________________

Briefly describe your symptoms:____
____

Have you ever had these symptoms before? ☐ Yes ☐ No

Have you had any falls in the past year? ☐ Yes ☐ No

Do you have or have you had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Osteoarthritis	☐	☐
High Blood Pressure	☐	☐	Rheumatoid Arthritis	☐	☐
Low Blood Pressure	☐	☐			
Osteoporosis	☐	☐			
Cancer	☐	☐	Metal Implants	☐	☐
Heart Disease	☐	☐	Joint Replacement	☐	☐
Spine Surgery	☐	☐			
Blood Clots/Vascular Disease	☐	☐	Fractures: ______________________________________		
Pacemaker	☐	☐	Dislocations: ___________________________________		
Headaches	☐	☐			
Migraines	☐	☐	Please List Current Allergies:		
Kidney Problems	☐	☐	____		
Thyroid Problems	☐	☐	____		
Bowel / Bladder Abnormalities	☐	☐	____		
Asthma	☐	☐	____		
COPD	☐	☐	____		
Smoking	☐	☐	____		
Stroke / CVA / TIA	☐	☐	____		
Seizures	☐	☐			
Epilepsy	☐	☐	Are you Pregnant?	☐	☐
Cancer	☐	☐			

Is there any other information regarding your past medical history that we should know about?
____
____
____

Are you presently taking medication? ☐ Yes ☐ No

If yes, please list what medications and for what condition: ☐ Please see attached medication list.

____
____
____

Please list all surgeries and dates of surgery:
____
____
____

What are your goals for physical/vestibular therapy?
____
____
____