KEE PHYSICAL THERAPY

Medical History Form

PATIENT NAME: _____ TODAY'S DATE: _____

REFERRING PHYSICIAN'S NAME: _____

DATE OF INJURY OR ONSET: _____

PRIMARY PHYSICIAN'S NAME: _____

ARE YOU PRESENTLY WORKING? YES NO

CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY 'FLU TYPE' SYMPTOMS (I.E. FEVER, COUGH)? YES NO

IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? _____ IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS A RESULT OF THE FALL? YES NO

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH (Circle one): EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (Circle one): YES NO IF YES, HOW MUCH? _____

DO YOU WEAR GLASSES/CONTACTS? YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO

IF YES, WHEN AND WHY: _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CONDITION? (Circle one): YES NO

WHAT WAS DONE?/WHAT WERE THE RESULTS?:

_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (Circle one): YES NO

WAS IT RECEIVED AT: (Circle one): HOSPITAL OUTPATIENT HOME HEALTH

FOR HOW LONG?: _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: _____

REACTION: _____

ARE YOU ALLERGIC TO LATEX: (Circle one): YES NO

IF YES, WHAT IS THE REACTION: _____

ARE YOU ALLERGIC TO DEXAMETHASONE? YES NO IF YES, WHAT IS THE REACTION: _____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)

- ❑ ANEMIA
- ❑ ARTHRITIS
- ❑ CANCER
- ❑ CARDIOVASCULAR PROBLEMS
- ❑ HOLTER MONITOR - Currently wearing?
  - ❑ PACEMAKER
  - ❑ HIGH BLOOD PRESSURE
    - ❑ CONTROLLED
    - ❑ UNCONTROLLED
- ❑ LOW BLOOD PRESSURE
- ❑ CURRENTLY PREGNANT
- ❑ DIABETES
  - ❑ CONTROLLED
  - ❑ UNCONTROLLED
- ❑ DEPRESSION
- ❑ DIZZINESS/FAINTING
- ❑ FRACTURES
- ❑ HEADACHES
- ❑ HEPATITIS/HIV
- ❑ KIDNEY PROBLEMS
- ❑ MRSA (Methicillin Resistant Staphylococcus Aureus)
- ❑ OSTEOPOROSIS
- ❑ RESPIRATORY PROBLEMS
- ❑ ASTHMA
  - ❑ CONTROLLED
  - ❑ UNCONTROLLED
- ❑ COPD
  - ❑ CONTROLLED
  - ❑ UNCONTROLLED
- ❑ OTHER:
- ❑ SEIZURES
  - ❑ CONTROLLED
  - ❑ UNCONTROLLED
- ❑ THYROID PROBLEMS
- ❑ BLOOD THINNERS (Anticoagulants)

If checked any of the above, explain: _____

Any other medical problems not listed: _____

SIGNATURE OF PATIENT:

_____

REVIEWED BY: _____ DATE: _____