PAST MEDICAL HISTORY
ROCKVILLE PHYSICAL THERAPY

Patient Name: _____ Date of Birth: _____

Reason for therapy: _____ Date of Injury/Onset: _____
Have you previously received therapy for this condition? ❑ yes ❑ no If so, when? _____
Previous treatment received? _____

For our female patients: Could you be or are you pregnant? ❑ yes ❑ no
Do you now or have you ever had any of the following medical conditions:

Arthritis	❑ yes ❑ no	Hepatitis	❑ yes ❑ no
Asthma	❑ yes ❑ no	Hernia	❑ yes ❑ no
Anemia	❑ yes ❑ no	High Blood Pressure	❑ yes ❑ no
Anxiety	❑ yes ❑ no	Infections	❑ yes ❑ no
Bladder Problems	❑ yes ❑ no	Kidney Problems	❑ yes ❑ no
Chronic Cough	❑ yes ❑ no	Metal in body	❑ yes ❑ no
Cancer	❑ yes ❑ no	Osteoporosis	❑ yes ❑ no
Clotting / DVT	❑ yes ❑ no	Osteopenia	❑ yes ❑ no
Diabetes	❑ yes ❑ no	Pacemaker	❑ yes ❑ no
Depression	❑ yes ❑ no	Respiratory Problems	❑ yes ❑ no
Dizziness	❑ yes ❑ no	Seizures	❑ yes ❑ no
Epilepsy	❑ yes ❑ no	Sensitivity to cold/hot	❑ yes ❑ no
Fainting Spells	❑ yes ❑ no	Shortness of Breath	❑ yes ❑ no
Fractures	❑ yes ❑ no	Stroke	❑ yes ❑ no
Gout	❑ yes ❑ no	Surgeries	❑ yes ❑ no
Headaches	❑ yes ❑ no	Swelling	❑ yes ❑ no
Head Injury	❑ yes ❑ no	Thyroid Problems	❑ yes ❑ no
Hearing Loss	❑ yes ❑ no	Tuberculosis	❑ yes ❑ no
Heart Attack	❑ yes ❑ no	Vascular Disease	❑ yes ❑ no
Heart Disease	❑ yes ❑ no	Weight Loss /Gain	❑ yes ❑ no
HIV/AIDS	❑ yes ❑ no	Other_____	

If you answered "yes" on any of the above, please explain and give approx dates and treatment:

_____
_____
_____
_____

Allergies? ❑ no ❑ yes, list allergies: _____

Are you presently taking any Medications? ❑ no ❑ yes, list medications and specify condition:

_____
_____
_____

This information is correct and complete to the best of my knowledge.

X _____ **Date:** _____
Patient / Parent / Guardian Signature