

Patient Name _____

Rev. 10/25/18

Have you ever had any of the below items? Please check all that apply.

General:

- Activity change
- Appetite change
- Chills
- Fatigue
- Fever
- Unexpected weight change

Endocrine:

- Heat intolerance
- Cold intolerance
- Diabetes

Allergy/Immune:

- No Known Allergies
- Environmental allergies
- Food allergies
- Latex
- Adhesives
- Other Allergies: _____

Musculoskeletal:

- Joint pain
- Back pain
- Neck pain
- Gait problem
- Joint swelling
- Muscle pain/soreness
- Arthritis
- Fractures
- Osteoporosis/penia

Neurological:

- Dizziness
- Headache
- Light-headedness
- Numbness
- Seizure
- Weakness
- Stroke

Do you smoke? Yes / No

Height: _____

Weight: _____

Cardiovascular:

- Chest pain
- Leg swelling
- Heart palpitations
- Heart attack
- High blood pressure
- Blood clot
- Pacemaker

Lung:

- Asthma
- Bronchitis
- COPD
- Shortness of Breath

Kidney:

- Renal failure
- Dialysis

Have you had cancer? Yes / No

If Yes, type of cancer: _____

Surgical History

Orthopedic:

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Shoulder Replacement | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ankle / Foot (circle) | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Wrist / Hand (circle) | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

Spine Surgery:

- Cervical (neck)
- Lumbar (lower back)

Cortisone / Epidural Injections:

Joint/Date _____

Other Surgeries:

Other medical conditions or details about above: _____

At present time, would you say that your health is: Excellent Good Fair Poor

Have you fallen in the past year? Yes / No If yes, how many times fallen? _____

Describe the circumstances of the fall: _____

Did you sustain an injury when you fell? Yes / No If yes, please explain: _____

Details: _____

Patient Signature: _____ Date: _____

(if patient is a minor parent/guardian must sign)

PT Notes: _____ PT Reviewed: _____