Mady & Mules Physical Therapy

Medical History / Review of Systems

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:

☐ Hip Replacement	☐ Right	☐ Left	☐ Both
☐ Knee Replacement	☐ Right	☐ Left	☐ Both
☐ Shoulder Replacement	☐ Right	☐ Left	☐ Both
☐ Hip	☐ Right	☐ Left	☐ Both
☐ Knee	☐ Right	☐ Left	☐ Both
☐ Ankle / Foot (circle)	☐ Right	☐ Left	☐ Both
☐ Shoulder	☐ Right	☐ Left	☐ Both
☐ Elbow	☐ Right	☐ Left	☐ Both
☐ Wrist / Hand (circle)	☐ Right	☐ Left	☐ 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: _____