PERSONAL EDGE PT MEDICAL HISTORY

NAME OF PERSONAL PHYSICIAN: ____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS YEAR? Y / N (# of Visits)______________________________

List any Prescription or Non-Prescription Medications:

DRUG	REASON

Please describe briefly the reason for today's visit: ____

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DO YOU NOW HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

YES NO High Blood Pressure
YES NO Chest pain or discomfort
YES NO Rapid Heart Beat or Palpitations
YES NO Extra of Skipped Heartbeats
YES NO Dizziness or Lightheadedness
YES NO Shortness of Breath
YES NO Kidney Disease
YES NO Cirrhosis of Other Liver Disease
YES NO Diabetes
YES NO Ulcer of Intestinal Bleeding
YES NO Hypoglycemia (low blood sugar)
YES NO High Cholesterol
YES NO Multiple Sclerosis/Parkinson's
YES NO Hernia
YES NO Thyroid Problems
YES NO Vision or Hearing Difficulty
YES NO Epilepsy/Seizures
YES NO Migraine or Recurrent Headaches
YES NO Persistent Cough
YES NO Increased Anxiety or Depression
YES NO Problems with Recurrent Fatigue
YES NO Trouble Sleeping
YES NO Pain in Legs Walking Short Distances
YES NO Multiple Joint Pain
YES NO Rheumatoid Arthritis
YES NO Osteoarthritis
YES NO Polio
YES NO Asthma/Emphysema
Other:
____

YES NO Night Sweats
YES NO Heart Attack(s)/Heart Surgery
YES NO Pacemaker
YES NO Osteoporosis/Osteopenia
YES NO Stroke/TIA
YES NO Coronary Artery Disease or Angina
YES NO Joint Replacement(any joint)
YES NO Infectious Disease(s)
YES NO Unexplained Weight Loss/Gain

FOR OFFICE USE ONLY:

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PATIENT SIGNATURE or PARENT SIGNATURE DATE