Fredericksburg Orthopaedic Associates, P.C.
Physical Therapy Institute

PERSONAL MEDICAL HISTORY FORM

After completing this form, print and sign at the bottom; and, provide to the receptionist when you check-in.

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Check all that apply and explain the following medical problems that you have had:

AIDS / HIV	Drug Abuse	Liver Disease
Allergies	Emphysema	Motor Vehicle Accident
Anemia	Fainting	Psychiatric Treatment
Arthritis	Fractures	Rheumatic Heart Disease
Asthma	Glaucoma	Seizures
Back Trouble	Heart Disease	Shortness of Breath
Bronchitis	Heart Attack	Sinusitis
Cancer	Heart Murmur	Stomach Ulcers
Chest Pain	Hepatitis	Stroke
Congenital Heart Defect	Herpes	Swelling of Hands / Feet
Congestive Heart Failure	High Blood Pressure	Thyroid Disease
Convulsions	Jaundice	Tuberculosis
Diabetes	Kidney Disease	Rheumatic Fever
Bleeding Disease		

2. List any operations or surgery that you have had:

3. Reasons for being referred to Physical Therapy:

4. List any medications you are currently taking:

5. List any allergies and describe any drug reactions:

6. Please check any of the following you may have / wear:

   Glasses   Contacts   Dentures   Pacemaker   Metal/Foreign Object Implant

7. Are you pregnant? Yes   No

8. Any significant weight gain/loss in the last year? Yes   No   (±) ___________ lbs

9. Are you under the care of any other medical/health provider or physician? Yes   No
   If Yes, for what condition are you being treated? ____

10. What do you expect to gain/accomplish in receiving physical therapy?

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TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.

Signature: ____ Date: ______________________