

PATIENT MEDICAL HISTORY FORM

COMSTOCK PHYSICAL THERAPY

Patient Name: _____ Date of Birth: _____

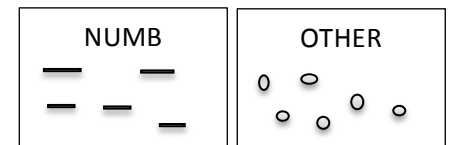
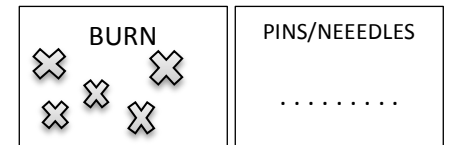
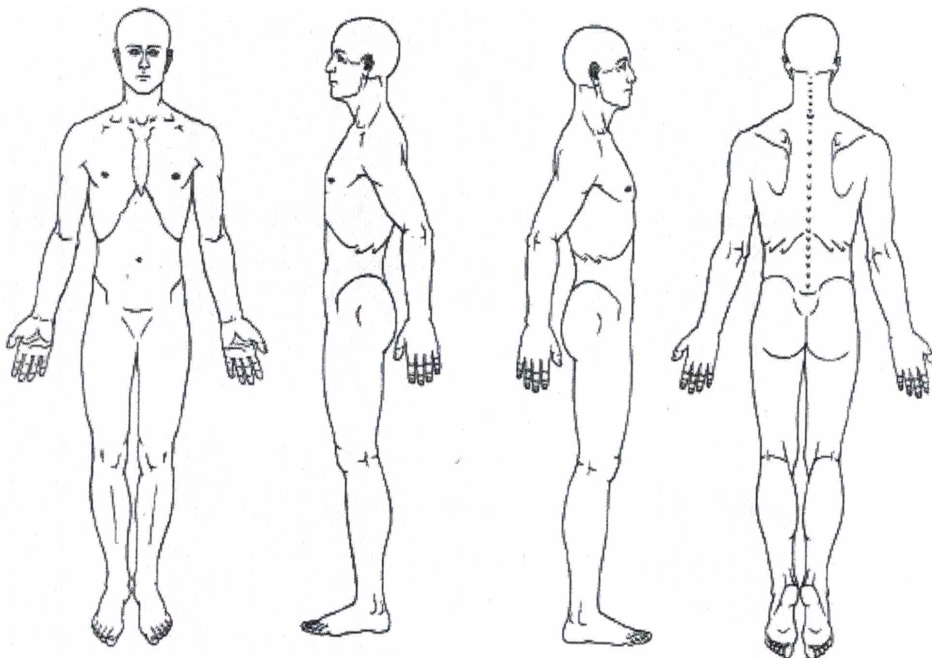
Date: _____ Occupation: _____ Diagnosis: _____

Last Physician Visit: _____ Next Physician Visit: _____

Do you have or have you had any of the following conditions:

Allergies	Yes <input type="radio"/> No <input type="radio"/>	Dizzy Spells	Yes <input type="radio"/> No <input type="radio"/>	MRSA	Yes <input type="radio"/> No <input type="radio"/>
Anemia	Yes <input type="radio"/> No <input type="radio"/>	Emphysema	Yes <input type="radio"/> No <input type="radio"/>	Multiple Sclerosis	Yes <input type="radio"/> No <input type="radio"/>
Anxiety	Yes <input type="radio"/> No <input type="radio"/>	Bronchitis	Yes <input type="radio"/> No <input type="radio"/>	Muscular Disease	Yes <input type="radio"/> No <input type="radio"/>
Arthritis	Yes <input type="radio"/> No <input type="radio"/>	Fibromyalgia	Yes <input type="radio"/> No <input type="radio"/>	Osteoporosis	Yes <input type="radio"/> No <input type="radio"/>
Asthma	Yes <input type="radio"/> No <input type="radio"/>	Fractures	Yes <input type="radio"/> No <input type="radio"/>	Parkinson's	Yes <input type="radio"/> No <input type="radio"/>
Autoimmune Disorder	Yes <input type="radio"/> No <input type="radio"/>	Gallbladder Problems	Yes <input type="radio"/> No <input type="radio"/>	Rheumatoid Arthritis	Yes <input type="radio"/> No <input type="radio"/>
Cancer	Yes <input type="radio"/> No <input type="radio"/>	Headache	Yes <input type="radio"/> No <input type="radio"/>	Seizures	Yes <input type="radio"/> No <input type="radio"/>
Cardiac Conditions	Yes <input type="radio"/> No <input type="radio"/>	Hearing Impairment	Yes <input type="radio"/> No <input type="radio"/>	Smoking	Yes <input type="radio"/> No <input type="radio"/>
Cardiac Pacemaker	Yes <input type="radio"/> No <input type="radio"/>	Hepatitis	Yes <input type="radio"/> No <input type="radio"/>	Speech problems	Yes <input type="radio"/> No <input type="radio"/>
Chemical Dependency	Yes <input type="radio"/> No <input type="radio"/>	High Cholesterol	Yes <input type="radio"/> No <input type="radio"/>	Stroke	Yes <input type="radio"/> No <input type="radio"/>
Circulation Problems	Yes <input type="radio"/> No <input type="radio"/>	High/Low Blood Pressure	Yes <input type="radio"/> No <input type="radio"/>	Thyroid Disease	Yes <input type="radio"/> No <input type="radio"/>
Currently Pregnant	Yes <input type="radio"/> No <input type="radio"/>	HIV/AIDS	Yes <input type="radio"/> No <input type="radio"/>	Tuberculosis	Yes <input type="radio"/> No <input type="radio"/>
Depression	Yes <input type="radio"/> No <input type="radio"/>	Incontinence	Yes <input type="radio"/> No <input type="radio"/>	Vision Problems	Yes <input type="radio"/> No <input type="radio"/>
Diabetes	Yes <input type="radio"/> No <input type="radio"/>	Kidney Problems	Yes <input type="radio"/> No <input type="radio"/>		
		Metal Implants	Yes <input type="radio"/> No <input type="radio"/>		

Please mark where your pain is, and what type of pain it is, on the body below:



FOR MEDICARE PATIENTS ONLY:

HEIGHT _____

WEIGHT _____

Describe any other conditions:

Fall History:

Injury as a result of a fall in the past year? Yes No

Two or more falls in the past year? Yes No

Patient is at risk for falls? Yes No

Surgical history:

Body Region: _____ Surgery Type: _____ Date: _____

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Current medications:

I have a medication list

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason: _____

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