BLUE BELL PHYSICAL THERAPY
MEDICAL HISTORY AND SYSTEMS REVIEW

Date: ____________

Name ____ **Age** _____________

Occupation/ Leisure Activities____

How did the problem occur? ____

When was the onset of your problem? ____

Onset (Check One) Gradual __________________ Sudden ________________

Where was the pain initially felt? ____

Now, where is the pain? ____ **Pain Rating (0-10)** __________________

How severe is your pain
Please mark your pain rating on the scale below

____

No Pain **Worst pain imaginable**

Type of pain Dull _________ Sore _________ Constant ___________ Intermittent __________

Sharp _________ Throbbing _________ Bruised ___________ Burning __________

Are you currently seeing any of the following:

Medical Doctor	YES	NO
Osteopath	YES	NO
Dentist	YES	NO
Psychiatrist/Psychologist	YES	NO
Chiropractor	YES	NO

If you have been seen by any of the above during the past three months, please describe for what reasons (illness, medical condition, physical exam, etc.) ____

____

____

Please list any surgeries/injuries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Surgery / Hospitalization / Reason
____________	____
____________	____
____________	____
____________	____
____________	____

Please initial _____

Please list ALL over-the-counter and prescription medications that you are currently taking. Please also provide the dosage of each medication.

Medications	**Dosage**					
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
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		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □
		Once a day □	Twice a day □	3x per day □	4x per day □	As needed □

By signing below, you acknowledge that this information is complete and accurate to the best of your knowledge:

_______________________________________ **Date:___________________**

(Patient or Guardian Signature)

How much coffee or other caffeine containing beverages do you drink a day? _____________________________

How many packs of cigarettes do you smoke a day? ____

How many days a week do you drink alcohol? ____

Have you or any of your family ever been diagnosed as having any of the following:

Cancer YES NO
If yes, please describe what kind:
____

Heart Problems YES NO
High Blood Pressure YES NO
Asthma YES NO
Emphysema YES NO
Chemical Dependency (e.g. alcoholism) YES NO
Thyroid Problems YES NO
Diabetes YES NO
Multiple Sclerosis YES NO
Rheumatoid Arthritis YES NO
Other Arthritic Conditions YES NO
Depression YES NO
Hepatitis YES NO
Tuberculosis YES NO
Stroke YES NO
Kidney Disease YES NO
Anemia YES NO
Epilepsy YES NO
Other ____

Please initial _____

Have You Had, Or Do You Experience:

Cardiovascular System	YES	NO
Elevated cholesterol	____	____
Sweating associated with pain	____	____
Palpitations	____	____
Swelling of extremities	____	____
History of smoking	____	____
Orthopnea (difficulty breathing)	____	____

GI System	YES	NO
Difficulty swallowing	____	____
Heartburn	____	____
Jaundice (yellow appearance)	____	____
Specific food intolerance	____	____
Constipation	____	____
Diarrhea	____	____
Change in color of stool	____	____
Rectal bleeding	____	____
Gall bladder problems	____	____
Liver Problems	____	____

G.U. System	YES	NO
Dysuria (painful urination)	____	____
Hematuria (blood in urine)	____	____
Incontinence	____	____
Frequency of urination	____	____
Urinary urgency	____	____
Vaginal discharge	____	____
Dysmenorrhea (painful menstruation)	____	____
Post menopausal vaginal bleeding	____	____
Painful intercourse	____	____
Infertility	____	____
Hx of STD	____	____
Date of Last Period	____	____

Pulmonary System	YES	NO
Dyspnea (labored breathing)	____	____
Wheezing	____	____
Prolonged cough	____	____
Sputum production	____	____

amount / color: ________________
____

Endocrine System	YES	NO
Excessive thirst	____	____
Excessive Hunger	____	____
Polyuria (large volume of urine)	____	____
Excessive sweating	____	____
Fatigue	____	____
Weakness	____	____
Thyroid problems	____	____

Neurological System	YES	NO
Ataxia (poor muscular coordination)	____	____
Memory lapses	____	____
Confusion	____	____
Head Trauma	____	____
Neurological disorder	____	____
Tremors	____	____
Slurred speech patterns	____	____
Hearing/Visual disturbances	____	____

Other System	YES	NO
ENT (ears, nose, throat)	____	____
Integumentary (skin)	____	____
Lymphatic	____	____
Psychiatric	____	____
Musculoskeletal	____	____

Goals for Physical Therapy (examples: climb stairs, get out of a car easier, increase walking time, return to prior activities)
____
____
____

Please tell us how you heard about us____
____
____

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Please initial _____