

**BLUE BELL PHYSICAL THERAPY
MEDICAL HISTORY AND SYSTEMS REVIEW**

Date: _____

Name _____

Age _____

Height _____ Weight _____ Occupation _____

Leisure Activities _____

Describe the reason of your visit _____

When was the onset of your problem? _____

Onset (Check One) Gradual _____ Sudden _____

How did the problem occur? _____

Was the injury a CONTACT or NON-CONTACT injury? _____

Did you hear any noise associated with the onset of the injury? _____

Where was the pain initially felt? _____

Now, where is the pain? _____

Type of pain Dull _____ Sore _____ Constant _____ Intermittent _____
Sharp _____ Throbbing _____ Bruised _____ Burning _____

Have you had any previous or similar problems? _____

Did you have swelling immediately? _____

What is the length of time your symptoms have been present? _____

Are you currently seeing any of the following:

Medical Doctor	YES	NO
Osteopath	YES	NO
Dentist	YES	NO
Psychiatrist/Psychologist	YES	NO
Physical Therapist	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 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 describe any injuries for which you have been treated (including fractures, dislocations, sprains, strains) and the approximate date of injury:

Date	Injury
_____	_____
_____	_____
_____	_____
_____	_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week:

Aspirin	YES	NO
Tylenol	YES	NO
Advil/Motrin/Ibuprofen	YES	NO
Laxatives	YES	NO
Decongestants	YES	NO
Antacids	YES	NO
Vitamins/Mineral Supplements	YES	NO
Antihistamines	YES	NO
Other	_____	_____

Please list any prescription medication that you are currently taking (including pills, injections, and/or skin pa

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 _____		

Date of last complete physical exam:

Month _____ Year _____ Physician _____

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	___	___