

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

Date: _____

Name _____

Age _____

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? _____ Pain Rating (0-10) _____

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

Have you had any previous or similar problems? _____

How long have you had the symptoms? _____

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 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 patches)

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	GI System	YES	NO
Elevated cholesterol	___	___	Difficulty swallowing	___	___
Sweating associated with pain	___	___	Heartburn	___	___
Palpitations	___	___	Jaundice (yellow appearance)	___	___
Swelling of extremities	___	___	Specific food intolerance	___	___
History of smoking	___	___	Constipation	___	___
Orthopnea (difficulty breathing)	___	___	Diarrhea	___	___
			Change in color of stool	___	___
			Rectal bleeding	___	___
			Gall bladder problems	___	___
			Liver Problems	___	___
G.U. System	YES	NO	Pulmonary System	YES	NO
Dysuria (painful urination)	___	___	Dyspnea (labored breathing)	___	___
Hematuria (blood in urine)	___	___	Wheezing	___	___
Incontinence	___	___	Prolonged cough	___	___
Frequency of urination	___	___	Sputum production	___	___
Urinary urgency	___	___	amount / color: _____		
Vaginal discharge	___	___			
Dysmenorrhea (painful menstruation)	___	___			
Post menopausal vaginal bleeding	___	___	Endocrine System	YES	NO
Painful intercourse	___	___	Excessive thirst	___	___
Infertility	___	___	Excessive Hunger	___	___
Hx of STD	___	___	Polyuria (large volume of urine)	___	___
Date of Last Period	___	___	Excessive sweating	___	___
			Fatigue	___	___
			Weakness	___	___
			Thyroid problems	___	___
Neurological System	YES	NO	Other System	YES	NO
Ataxia (poor muscular coordination)	___	___	ENT (ears, nose, throat)	___	___
Memory lapses	___	___	Integumentary (skin)	___	___
Confusion	___	___	Lymphatic	___	___
Head Trauma	___	___	Psychiatric	___	___
Neurological disorder	___	___	Musculoskeletal	___	___
Tremors	___	___			
Slurred speech patterns	___	___			
Hearing/Visual disturbances	___	___			

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