



**CONFIDENTIAL PATIENT HEALTH HISTORY FORM**

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

DOB \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

**Please place an "X" in the space provided if you have had any of the following conditions:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Pacemaker      |
| <input type="checkbox"/> Prolapsed Mitral Valve      | <input type="checkbox"/> Artificial Prosthesis | <input type="checkbox"/> Metal Implant  |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Hearing Loss          | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Pregnant              | <input type="checkbox"/> Sinusitis      |
| <input type="checkbox"/> AIDS                        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> Leukemia                    | <input type="checkbox"/> Rheumatic Fever       |   |
| <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Arthritis             |   |
| <input type="checkbox"/> Mental/Psychiatric Disorder | <input type="checkbox"/> HIV                   |   |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Kidney Disease        |   |
| <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Thyroid Disease       |   |
| <input type="checkbox"/> Other _____                 |  |   |

**Please list any surgeries you have had related to your current physical therapy problem:**

\_\_\_\_\_  
\_\_\_\_\_

**Please list any previous surgeries:**

\_\_\_\_\_

**Please list any medications you take:**

\_\_\_\_\_

Who is your family Physician? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_