MIDWESTERN UNIVERSITY MULTISPECIALTY CLINIC
PHYSICAL THERAPY – MEDICAL HISTORY

NAME: _____ **DATE OF BIRTH:** ____/_____/_____

PREFFERED NAME & PRONOUN: _____

Referring Physician: _____ Date last seen: _____/_____/_____

Have you received home health services in the last 30 days? _____Yes _____No
Are you currently receiving other care for this condition? (If yes, describe below.) _____Yes _____No

_____

Which best describes your current health? _____ Excellent _____ Good _____ Fair _____ Poor

Height:_____ Weight:_____

Please list any allergies: _____

Medical History: Please indicate if you have had any of the following conditions and explain below:

__ Acid reflux/Heartburn
__ Alcoholism
__ Allergies/Hay fever
__ Anxiety
__ Asthma/Wheezing
__ Back pain
__ Bladder Issues
__ Bowel Issues
__ Cancer (list type & location)
__ Changes in vision
__ Chest pain
__ Other (explain)
__ Chronic cough
__ Chronic fatigue
__ Chronic pain
__ COPD
__ Depression
__ Diabetes
__ Difficulty sleeping
__ Dizziness
__ Enlarged prostate
__ Fibromyalgia
__ Frequent headaches
__ Gallbladder disease
__ Heart disease
__ Hernia (list type)
__ High blood pressure
__ Kidney disease
__ Liver disease
__ Memory loss
__ Mental illness
__ Muscle weakness
__ Numbness/tingling
__ Osteoarthritis
__ Osteoporosis
__ Recent weight loss
__ Rheumatoid arthritis
__ Seizures
__ Sexual Dysfunction
__ Shortness of breath
__ Stroke
__ Swelling of extremities
__ Tendonitis
__ Thyroid disease

_____
_____
_____

SOCIAL HISTORY

Alcohol: __Never
__Occasional
__Drinks per day/week

Marital Status: __Single __Married __Divorced
__Widowed __Domestic Partner

Smoking: __Never
__Former (__cig per day __# of years)
__Current (__cig per day __# of years)

Occupation: _____

Tobacco (chewing): __No
__Yes (__cans per day/week)

Leisure Activities/Exercise Habits (List type and frequency):
_____
_____

Caffeine: __cups per day (coffee, tea, soda)

Diet/Nutrition: Do you follow a healthy diet? __Yes __No
Special diet? (Explain below.)
_____

Sleep patterns: __hours per night

Patient Signature: _____ **Date:**_____/_____/_____ **(continue next page)**

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NAME: _____ **DATE OF BIRTH:** ____/_____/_____

Does anyone in your family have a history of the following?:

__Heart Disease _____

__Cancer (list type): _____

__Diabetes _____

__Other: _____

Have you had an eye exam in the last year? __Yes __No **Have you fallen in the last year?** __Yes __No

List all current medical problems and current testing/test results:

_____

_____

_____

List all hospitalizations, childbirths, surgeries, past serious illnesses (include approximate dates):

_____

_____

_____

Please list all fractures, motor vehicle accidents, other accidents or traumas (include approximate dates):

_____

_____

_____

Do you have any metal in your body? __Yes __No **If yes, where?** _____

List all current medications. Please include any over-the-counter and/or natural supplements. Include dosage.

Name of Medication	Strength (mg, units, etc.)	Quantity	How often do you take it?