Competitive Edge

Medical History Information Sheet

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0=no pain, 10=worst pain imaginable) _____

2. Do you now or have you ever had the following?

		Explain
Stroke	*yes* _____ *no* _____	_____
Heart Disease or Heart Murmur	*yes* _____ *no* _____	_____
High Blood Pressure	*yes* _____ *no* _____	_____
Asthma	*yes* _____ *no* _____	_____
Diabetes	*yes* _____ *no* _____	_____
Epilepsy/Fainting	*yes* _____ *no* _____	_____
Impairment of Vision or Hearing	*yes* _____ *no* _____	_____
Cancer	*yes* _____ *no* _____	_____
Drug Allergies	*yes* _____ *no* _____	_____
Osteoporosis	*yes* _____ *no* _____	_____

Orthopaedic History – Please give dates & treatments received:

3. Have you ever sprained, strained, dislocated or fractured the following:

   Neck/Head (including concussion) _____

   Trunk (ribs, vertebrae, sternum) _____

   Low Back (vertebrae, discs, nerves) _____

   Upper Extremity (shoulder, elbow, wrist, arm) _____

   Lower Extremity (hip, leg, knee, ankle, foot) _____

4. Please list any surgeries that you have had and their dates:
   _____

5. Please list medication(s) presently taking: _____

6. Women: Are you pregnant? yes _____ no _____

7. Have you ever had PT in the past?_____
   If so, when? _____

8. **IF YOU HAVE MEDICARE, HAVE YOU EVER HAD HOME HEALTH CARE?**_____

   If so, what is the **name and phone number** to the agency? _____

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately

Signature_____Date:_____