Medical History Form

CAROLINA BEACH CBPT PHYSICAL THERAPY

PERSONAL INFORMATION

Name: _____ **Date:** _____

Gender: _____ **D.O.B.:** _____

HISTORY

Exercise Frequency: _____ **Exercise Type:** _____

Do you smoke?: Y N **Smoked in the past:** Y N **How Often:** _____

Are you pregnant? Y N **Do you have a pacemaker?** Y N

Allergies: _____

Current Medications: _____

Have you had any of the following? (Circle all that apply):

Arteriosclerosis	Circulation Problems	Hemophilia	Pneumonia
Arthritis	Drug Use	Heart Problems	Stroke/TIA
Asthma	Depression	High Blood Pressure	STD
Blood Clots	Diabetes	Lung Problems	Tuberculosis
Bone Infection	Epilepsy	Liver Problems	Urinary Infection
Cancer	Eye Infection	Low Blood Pressure	
COPD	Heart Attack	Multiple Sclerosis	

Other problems/diagnoses: _____

Other surgeries: _____

_____ _____

Signature of Patient or Parent Date