# PATIENT MEDICAL HISTORY

NAME: _____ BIRTHDATE: _____

MEDICAL DOCTOR: _____

| | (Please Circle) |
|---|---|
| 1) Have you been under the care of a physician during the past 2 years? | YES NO |
| 2) If female, are you now pregnant? | YES NO |
| 3) Are you presently using any medications or drugs? | YES NO |
| 4) Are you subject to any nervous disorders or fainting? | YES NO |
| 5) Have you been hospitalized or had any surgery in the last 5 years? | YES NO |
| 6) Have you had any other serious illness? | YES NO |

7) Circle any of the following which you have had or now have:

| | | |
|---|---|---|
| AIDS | Artificial Heart Valves | Heart Trouble |
| Allergies | Congenital Heart Lesions | Heart Murmur |
| Anemia | High Blood Pressure | Rheumatic Fever |
| Arthritis | Psychiatric Treatment | Tuberculosis |
| Asthma | Artificial Joints | Cancer Treatment |
| Cough | Cardiac Pacemaker | Kidney Treatment |
| Stroke | Diabetes | Epilepsy |

I hereby grant permission for Physical Therapy to be performed on this minor and will assume all responsibilities connected with such treatment.

Signature _____ Signature _____

(Patient/Parent or Guardian) (Physical Therapist)