Arizona OrthoSports PT and InMotion PT and Wellness

PATIENT HEALTH HISTORY

	YES *	NO
Have you been hospitalized or had surgery ? Please give dates & description below:		
Have you recently been ill (last 6 months)? *Describe:*		
Have you had any recent weight loss or gain (over 15 pounds)?		
Besides dental work, do you have any implanted metal or plastic in your body? *Where?*		
Do you have allergies ? *Describe:*		
Do you smoke? *How much?*		
Do you drink alcoholic beverages? * How much?*		
Have you had an eye examination in the past year ?		
Do you plan to be at your regular job in 6 months ?		

Mark (X) if you have any of the following problems:

High blood pressure		Emphysema		Eating disorder	
Unusual cardiac findings		Asthma		Stomach problems	
Shortness of breath		Bronchitis		Bowel or bladder problems	
Chest pain		Hepatitis A B C		Osteoporosis	
Extreme fatigue or tiredness		Diabetes		Gout	
Cancer		Peripheral vascular disease		Osteoarthritis	
Irregular thyroid		Epilepsy		Rheumatoid Arthritis	
Poor quality sleep		Sexual difficulties		Lupus	

Other:

List any regular exercise activity. _____

_____

What medications are you currently taking ? _____

_____

Date of last comprehensive physical ? _____ *Females:* Date of last gynecological exam? _____

**** NOTIFY YOUR THERAPIST IMMEDIATELY IF YOU BECOME PREGNANT**