



Patient Medical History

New Patient ☐ Previous Patient ☐ Previous Problem:

Referring Physician:

Patient Name: Occupation:

DOB: Height: Weight: Age:

Smoking History (Packs/day):

Alcohol consumption (Drinks/ day):

Preferred Pharmacy (Name/ Location):

Pharmacy Phone: Pregnant: Yes ☐ No ☐

List All Allergies / Drug Allergies:

List all Current Medications/Dose/Indication:

Family History:

List Current Fitness Activities:



Past Injuries/Surgeries/Hospitalizations:

Medical Conditions:

Reason For your visit today:

List any evaluation / treatment / testing / utilizations you used to help with your problem:

Additional comments you deem necessary for your Physical Therapist to know:



Patient Signature

Date



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