College Park Physical Therapy

Patient Medical History

Please complete this form in its entirety.

Patient Name _____

Street Address _____

City, State & Zip _____

Phone # _____

Spouse Name _____

How did you com to hear about CPPT? _____

Age _____

D.O.B. _____

Ht. _____

Wt. _____

Never Married ☐

Married ☐

Divorced ☐

Separated ☐

Widowed ☐

HABITS

Do you smoke? ☐ # of pkgs/day _____

Do you chew? ☐ amount/day _____

Do you drink alcohol? ☐ # drinks per day _____

Do you drink caffeine? ☐ # drinks per day _____

List any other recreational substances/drugs you use:

_____

Do you exercise? _____

Describe: _____

MEDICATIONS-List any medications you take regularly including over-the-counter, vitamins and/or minerals:

Name	Dosage
1.	
2.	
3.	
4.	
5.	

Today's date: _____

Date of last MD examination: _____

Past medical history: (please check)

Asthma	☐ Yes	☐ Family History
High Blood Pressure	☐ Yes	☐ Family History
Heart Problems	☐ Yes	☐ Family History
Neurologic Disorders	☐ Yes	☐ Family History
Pacemaker	☐ Yes	☐ Family History
Stroke	☐ Yes	☐ Family History
Osteoporosis	☐ Yes	☐ Family History
Blood Clots	☐ Yes	☐ Family History
Diabetes	☐ Yes	☐ Family History
Cancer	☐ Yes	☐ Family History
Seizures	☐ Yes	☐ Family History
Tuberculosis	☐ Yes	☐ Family History
Birth Defects	☐ Yes	☐ Family History
Osteoarthritis	☐ Yes	☐ Family History
Are you pregnant?	☐ Yes	☐ No

Other _____

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ALLERGIES- Are you allergic to the following? (Please check)

☐ Yes ☐ No **Drugs- list** _____

☐ Yes ☐ No **Food- list** _____

☐ Yes ☐ No **Latex**

☐ Yes ☐ No **Environmental**

☐ Yes ☐ No **Other- describe**

To be completed by CPPT staff:

Initials _____

Date _____

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Patient & Family Medical History

Patient Name: _____

Patient DOB: _____

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us:

Condition	I Had	When	Family (Specify Relationship)
Arthritis	☐		
Sciatica	☐		
Back Problems	☐		
Neck Problems	☐		
Sprain/Strain	☐		
Headaches	☐		
Hand Problems	☐		
Jaw Pain	☐		
Shoulder Pain	☐		
Knee Pain	☐		
Hip Pain	☐		
Ankle Pain	☐		
Osteoporosis	☐		
Balance Issues/Falls	☐		

Other	I Had	When	Description
Surgery (Shoulder/Elbow/Hand)	☐		
Surgery (Hip/Knee/Ankle)	☐		
Surgery (Neck/Back)	☐		
Pregnancy/Delivery (ies)	☐		
Motor Vehicle Accident w/Injury	☐		

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Please describe any additional medical issues not addressed above.

How is this issue affecting you in the areas listed below:

Financially: _____

Emotionally: _____

Socially: _____