

PAST MEDICAL HISTORY FORM
Patient Name _____

BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Implants	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	YES	NO	OTHER CONDITIONS	YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION	YES	NO	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Previous Fractures	<input type="checkbox"/>	<input type="checkbox"/>
			Previous Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____		

LUNGS	YES	NO			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor		
What types of exercise do you perform? : _____			

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
 YES NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative

Date