Maryland Physical Therapy and Wellness Center
Patient Medical Information Form

Name: _____ Date: _____

Chief Complaint(s): _____

Age: _____ Occupation:_____ Full Time: ____ Part Time: ____

How did the injury occur? _____

Where did the injury occur? _____

Is this work related? Yes___ No ___ Is this auto related? Yes ___ No ___ Is this an accident case? Yes ___ No ___

Please check the following:

1. ALLERGIES?
___ None
___Sulfa
___Cephalosporin
___Environmental
___ Other:
LIST: _____

2. Current Medication(s)
Please list all medications taking:
_____
_____
_____
_____
_____

3. Prior Surgeries
Please list all prior surgeries:
_____
_____
_____
_____

4. Do you SMOKE?
Yes ___ Packs per day _____ How many years _____
No ___
Never ___
Quit: ___ How Long Ago? ____

5. Do you drink ALCOHOL ?
Yes ___ How much on average? _____
No ___
Never ___
Quit: ___ How Long Ago? ____

6. Do you use STREET DRUGS?
Yes ___ How much on average? _____
No ___
Never ___
Quit: ___ How Long Ago? ____

7. Do you live alone? Yes ___ No ___
8. Are you married? Yes ___ No ___
9. Are there steps in your house? Yes ___ No ___
10. Are you Right ___ Left ___ Handed?
11. What is your Height _____ Weight _____?
12. Date of last physical?_____
By Whom? _____

Please check the following if they apply:

YOURSELF

Heart Problems _____
Heart Murmur _____
High Blood Pressure _____
High Cholesterol _____
Asthma _____
Emphysema _____
Stroke _____
Hepatitis _____
Thyroid Problems _____
Stomach/Ulcer _____
Tuberculosis _____
Joint Problems _____
Kidney/Bladder _____
Cancer _____
Bleeding/Bruising _____
Immune Problems _____
Blood Transfusions _____
Diabetes _____
Osteoporosis _____
Gout _____

YOUR FAMILY

Heart Problems _____
Heart Murmur _____
High Blood Pressure _____
High Cholesterol _____
Asthma _____
Emphysema _____
Stroke _____
Hepatitis _____
Thyroid Problems _____
Stomach/Ulcer _____
Tuberculosis _____
Joint Problems _____
Kidney/Bladder _____
Cancer _____
Bleeding/Bruising _____
Immune Problems _____
Blood Transfusions _____
Diabetes _____
Osteoporosis _____
Gout _____