RIDGE PHYSICAL THERAPY & WELLNESS CENTER

Patient's Medical History

Today's Date:_____

Patient name: _____ Sex: M F

Age: _____ Height / weight: _____

Occupation: _____

Leisure activities / hobbies: _____

Referring Physician: _____

Check those that Apply:

_____Recent illness, hospitalizations or surgical procedures
_____Heart Attack, coronary bypass, cardiac surgery
_____Abnormal resting or stress ECG
_____Uneven, irregular, or skipped heart beats (including a racing or fluttering heart)
_____High Cholesterol
_____High Blood Pressure
_____Incontinence (urge, stress, leaking of bladder with coughing or sneezing)
_____List **ALL** past surgeries:_____
_____Diabetes
_____Blood Clots
_____Stroke
_____Pulmonary Disease (asthma, emphysema, bronchitis, other breathing problems)
_____Cancer
_____Pregnant - How many months along? _____
_____Ulcers
_____Orthopedic problems or injuries (arthritis or any other bone, joint, or muscle problems)
_____Emotional / psychological disorders (including stress, anxiety, or sleep disturbances)
_____Physical Inactivity
_____Smoking
_____Medications: _____
_____Allergies: _____

Please List any other health problems:_____

Please indicate any current or past forms of exercise that you have participated in:
_____
_____

What do you hope to achieve in therapy?:_____
_____