

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?: _____
