Hingham Physical Therapy, Inc.

Past Medical History

Name: ____ DOB:______________________

Problem bringing you to PT: ____

When did problem start? __________________________ Currently working? YES/NO (circle)

Injury related to: Work _____ Motor vehicle accident _____ Sports/Activity _____

Recurrence of previous _____ Fall _____ Unknown Cause _____

Have you had previous treatment or surgery related to this problem? YES/NO (circle)

Have you had physical therapy previously this year for any diagnosis? YES/NO (circle)

Please circle any conditions that you have had

Asthma/Lung problem	Headache
Arthritis (rheumatoid)	Hernia
Arthritis (osteoarthritis)	Heart attack
Allergy to latex	Kidney problems
Allergies	Liver problems
Balance difficulty	Neurological conditions
Bowel/Bladder abnormalities	Pacemaker
Cancer	Pregnancy - Current
Cardiac issues/Heart disease	Seizures
Diabetes	Skin conditions
Dizziness/Fainting	Stroke
Gout	Surgeries

Please give brief explanation of any conditions and list medications taking for above conditions:

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Is there anything else we should know about your medical history? ______________________

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Emergency contact (name, relationship, number): ________________________________