DPT
DITZLER PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Name:_____ Date:_____ Date of Birth: _____
Referring Physician:_____Family Physician: _____
Your chief complaint:_____
Date of Injury: _____If not an injury, date of onset of symptoms:_____
Date of 1st doctor visit for this injury:_____ Are you aware of what your diagnosis is? ☐ Yes ☐ No
What are your rehabilitation expectations or goals? _____
_____
Occupation: _____ or ☐ Retired ☐ Student
Work Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Off work
Last Date Worked Due to this injury: _____ Date Returned to Work after This Injury: _____
Have you had a Surgery for this injury: ☐ Yes ☐ No Type of Surgery? : _____
Approximate date(s) of surgery: _____

Have you had any of the following Medical or Rehabilitation Services for this injury/Episode, Please circle?

X-Ray	Y	N	Myelogram	Y	N	General Practitioner	Y	N
MRI	Y	N	Physical therapy	Y	N	Orthopedist	Y	N
CT-scan	Y	N	Occupational therapy	Y	N	Neurologist	Y	N
EMG / nerve conduction	Y	N	Massage therapy	Y	N	Emergency room care	Y	N

Please circle yes or no if you have, or have had, any of the following problems:

Constitutional			**Respiratory**			**Gastrointestinal**		
Good general health	Y	N	Shortness of Breath	Y	N	Nausea / Vomiting	Y	N
Recent weight changes	Y	N	Excessive coughing	Y	N	Abdominal pain	Y	N
Fatigue	Y	N	Asthma	Y	N	Rectal bleeding	Y	N
Night sweats / fever	Y	N	Bronchitis	Y	N	Blood in urine	Y	N
Cardiovascular			Emphysema	Y	N	Kidney stones	Y	N
Hypertension / High Blood Pressure	Y	N	**Neurological**			**Other**		
Angina / chest pain	Y	N	Frequent headaches	Y	N	Changes in hair or nails	Y	N
Coronary artery disease	Y	N	Seizures / Epilepsy	Y	N	Rashes or itching	Y	N
Heart surgery / Pacemaker	Y	N	Numbness / tingling	Y	N	Breast lump	Y	N
Musculoskeletal			Dizziness	Y	N	Breast pain or discharge	Y	N
Muscle pains or cramps	Y	N	Weakness	Y	N	Changes in menstrual cycle	Y	N
Stiffness / swelling in joints	Y	N	Stroke/TIA	Y	N	Tuberculosis	Y	N
Joint pain	Y	N	**Hematologic/Lymphatic**			Cancer	Y	N
Osteoporosis	Y	N	Bruise easily	Y	N	Chemotherapy or radiation	Y	N
Endocrine			Slow to heal	Y	N	HIV/AIDS	Y	N
Excessive thirst / urination	Y	N	Enlarged glands	Y	N	Diabetes	Y	N
Thyroid disease	Y	N	**Eyes**			Blood clots	Y	N
Hormone problem(s)	Y	N	Wear glasses / contacts	Y	N	Depression	Y	N
Ear/Nose/Throat/Mouth			Blurred / double vision	Y	N	Insomnia	Y	N
Hearing loss/ringing in ears	Y	N	Eye disease or injury	Y	N	Confusion or memory loss	Y	N
Sinus problems	Y	N	Glaucoma	Y	N	Memory loss	Y	N
Nose bleeds	Y	N	**Allergies**			Do you smoke	Y	N
Sore throat	Y	N	Food	Y	N	Use tobacco products	Y	N
Voice changes	Y	N	Medicine	Y	N	Are you pregnant	Y	N

Patient Signature: _____ Date: _____ Therapist Signature: _____Date:_____