New Patient Medical History **Date:** _____

Patient Name: _____ **Do you have an Advance Directive? (Only Medicare PT's)** YES NO

Reason for visit: _____

Primary Care Physician: _____ Phone: _____

Patient's occupation: _____ Employer: _____

Is your visit due to an accident or injury? (Please circle) YES NO **If so, did it occur at work?** YES NO

Are you breast feeding and/or pregnant? YES NO

Please list all prescription and over the counter medications that you are currently taking, with dose:

_____

_____

Do you have or are you being treated for any of the following? (Please circle)

Anemia Asthma Arthritis Diabetes Drug Reactions HIV/AIDS Heart disease High Blood Pressure Stomach/Intestinal Disorders

Are you allergic to: (Please circle) Sulfa Drugs Hydrocodone Aspirin Penicillin Local anesthetic Latex Adhesive tape Other: _____

Please list significant illnesses, injuries, or surgeries within the past 5 years:

_____

Family history: Mother: Alive Deceased Health History: _____

Father: Alive Deceased Health History: _____

How many? Brother(s): ____ **Sister (s)** _____ **Health History:** _____

Son(s): _____ **Daughter(s):**____ **Health History:** _____

Smoking Status: (Please circle one) Current Smoker Former Smoker Non-smoker

Chewing Tobacco: (Please circle) Never Current user Former smoker Other

Do you drink alcohol? YES NO **If yes, what type?** Wine Beer Liquor **How often?** Socially Daily Rarely

Do you exercise regularly? YES NO **If yes, what type?** Walking Running Biking Swimming Hiking Yoga Pilates Zumba Other

Use of recreational drugs? YES NO **If yes, what type**? _____ **How often?** _____

Shoe size: _____ **Height**: (***preferably in inches**): _____ **Weight**: _____

Review of Systems:

Please indicate if you have any of the following:

Endocrine:

Feeling Cold/Cold Intolerance
Diabetes
Excessive Thirst

Respiration:

Trouble Breathing/ COPD
Chest Pressure/Congestion
Cough
Dry Mouth
Shortness of Breath

Cardiology:

Chest Pain
Dizziness
Fainting
Fatigue
High Blood Pressure
History of Heart Attack
Irregular Heartbeat/Heart Murmur
Known Coronary Artery Disease
Ankle/Leg Swelling
Pacemaker
Palpitations

Gastroenterology:

Abdominal Pain
Acid Reflux
Blood in Stool/Rectal Bleeding
Constipation
Diarrhea
Nausea/Vomiting
Weight Gain/Weight Loss

Musculoskeletal:

Muscle Pain
Splinter/Foreign Object in Foot
Arthritis
Bone Pain
Foot Pain/Fracture
Joint Pain/Joint Swelling

Dermatologic:

Lesions
Plantar Warts
Dry/Sensitive Skin
Nail Changes
Foot Ulcers
Thickened Toenails
Ingrown Toenail

Integumentary:

Healing Problems
Melanoma/Skin Cancer
Suspicious Moles
Suspicious Lesions
Easy Bruising

Neurologic:

Balance Difficulty
Burning in Hands/Feet
Confusion
Gait Abnormalities
Headaches/Migraine Headaches
Loss of Sensation
Memory Loss
Peripheral Neuropathy
Seizures
Strokes
Tremors
Tingling/Numbness in Hands/Feet
Visual Changes
Weakness