



Physical and Occupational Therapy at Home or Clinic
Medicare Provider

Office (561) 859-6711 Fax (888) 737-0680

10151 Enterprise Ctr. Blvd. Suite 107 Boynton Beach, FL 33437

FAU Memory & Wellness Center 777 Glades Rd. Boca Raton, FL 33431

Past Medical History Form

Patient Name: _____

Date: _____

Are you presently working? Yes No

Date of next physicians visit: _____

Date of injury/onset: ____/____/____

Have you ever had these symptoms before? Yes No

Check which apply to your symptoms:

- Work related injury
- Recurrence of previous injury
- Motor vehicle accident
- Injury related to lifting
- Cause unknown
- Athletic/recreational injury
- Injury related to falling
- Other

Have you had a related surgery? Yes No

Do you have or have you had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Poor Tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine leakage	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver/Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>

If yes on any of the above, please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know about

Are you presently taking medication? Yes No

If yes, please list what medications and for what condition:

