MIGNACCA
PHYSICAL THERAPY, Ltd.
Moving You Forward

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Past Medical History for _____

(Name of Patient)

Yes	No	1. Do you have high blood pressure? Is it controlled with medication? YES or NO
Yes	No	2. Do you have heart problems?
Yes	No	3. Do you have a pacemaker?
Yes	No	4. Do you experience frequent heart palpitations?
Yes	No	5. Do you have angina (chest pain with exertion)?
Yes	No	6. Do you have a heart murmur?
Yes	No	7. Do you have an abnormal heart rate?
Yes	No	8. Do you have high cholesterol? Controlled with Medication? Yes or No
Yes	No	9. Do you have problems with shortness of breath?
Yes	No	10. Do you have asthma?
Yes	No	11. Do you have chronic lung problems?
Yes	No	12. Do you have chronic heartburn, stomach, or intestinal upset?
Yes	No	13. Do you have a history of ulcers?
Yes	No	14. Have you experienced significant recent weight loss or gain?
Yes	No	15. Do you have any bowel and/or bladder problems? (e.g. constipation, diarrhea, urgency to urinate)
Yes	No	16. Do you have thyroid problem? Type: _____
Yes	No	17. Do you have diabetes? Medication dependent? Yes or No
Yes	No	18. Do you have low blood sugar? e.g. Hypoglycemia
Yes	No	19. Do you have or have had any cancer? here? _____ When? _____
Yes	No	20. Do you have osteoporosis?
Yes	No	21. Do you have a history of back and/or neck pain?
Yes	No	22. Do you have headaches?
Yes	No	23. Do you have a history of seizures?
Yes	No	24. Do you have unusual joint pain and swelling unrelated to trauma?
Yes	No	25. Do you have a history of fractures? Where? _____
Yes	No	26. Do you have metal implants? Where? _____
Yes	No	27. Do you smoke? How often? _____
Yes	No	28. Do you participate in a regular physical exercise program? Type: _____ Frequency?_____
Yes	No	29. Do you wear contact lenses or glasses?
Yes	No	30. Do you have impaired hearing?
Yes	No	31. Do you have any chronic immune deficiency conditions?
Yes	No	32. Do you have allergies? List: _____
Yes	No	33. Are you pregnant or suspect that you are pregnant?
Yes	No	34. Do you have dysmenorrheal (abnormal menstrual cycles)?
Yes	No	35. Are you currently being treated for any other condition not listed?

g. depression, anxiety, etc.)

Current Condition

1. Chief Complaint/ Current Condition	_____
2. Pain Level - at worst	0 1 2 3 4 5 6 7 8 9 10 (0 = no pain; 10 = emergency room pain)
Pain Level - current	0 1 2 3 4 5 6 7 8 9 10
Pain Level - at best	0 1 2 3 4 5 6 7 8 9 10
3. Surgery/Date	_____
4. Other Medical Professions Involved	*(Please circle all that apply)* Primary Care Physician Podiatrist Orthopedist Physical Therapist Chiropractor Neurologist/Neurosurgeon
5. Diagnostic Tests	*(Please circle all that apply)* X- Ray CT Scan MRI Bone Scan EMG Blood Chemistry OTHER

Current Symptoms

Yes	No	1. Do you have 'pins & needles' or numbness sensation in your extremities?
Yes	No	2. Do your arms, hands, legs or feet swell as a result of your current condition?
Yes	No	3. Do you have weakness in your arms or legs?
Yes	No	4. Do you have any coordination and/or balance problems?
Yes	No	5. Do you have difficulty walking?
Yes	No	6. Do you experience dizziness/vertigo (feeling of spinning) with a change in position? (e.g. getting up from lying down)
Yes	No	7. Do you have episodes of blurred or double vision?
Yes	No	8. Have you experienced headaches as a result of your condition?
Yes	No	9. Do you have ringing in the ears?

I believe all information to be true and complete and will contact Mignacca Physical Therapy, Ltd. if it changes during the course of my care.

Signature: _____ Date: _____