

RESTOR Physical Therapy @ Shoreline  
1235 Pear Ave. Ste. 101  
Mountain View, Ca 94043  
650.965.8434  
Fax 650.965.8545

### MEDICAL HISTORY

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Sex: M F

Occupation \_\_\_\_\_ Activities and hours involved in occupation (e.g., sitting, standing, bending, lifting, walking, etc.) \_\_\_\_\_

Sports, hobbies, other activities and frequency/hours involved \_\_\_\_\_

Reason for therapy (traumatic or gradual onset) \_\_\_\_\_

Date of injury/onset \_\_\_\_\_ Surgical Procedure & Date \_\_\_\_\_

#### Have you or any immediate family member ever

Been told you have:	Self		Family	
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
High blood pressure	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
Angina/Chest pain	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No
Osteoarthritis	Yes	No	Yes	No
Rheumatoid Arthritis	Yes	No	Yes	No

#### Do you have a history of:

Allergies/Asthma	Yes	No
Headaches	Yes	No
Bronchitis	Yes	No
Kidney Disease	Yes	No
Rheumatic Fever	Yes	No
Ulcers	Yes	No
Pacemaker	Yes	No
Metal Implants	Yes	No

#### Are your symptoms (check one):

Getting worse  The same  Improving

#### Have you had or do you experience:

A change in you health	Yes	No
Nausea/Vomiting	Yes	No
Fever/Chills/Sweats	Yes	No
Unexplained weight change	Yes	No
Numbness/Tingling	Yes	No
Changes in appetite	Yes	No
Difficulty swallowing	Yes	No
Changes in bowel or bladder function	Yes	No
Shortness of breathe	Yes	No
Dizziness	Yes	No

#### Are you able to sleep at night (check one):

Fine  Moderate Difficulty  Only with medication

#### Do you have problems with:

Hearing  Vision  Speech or English

#### Do you drink alcoholic beverages? Yes No

If yes, \_\_\_\_\_ / week

#### Do you or have you in the past smoked tobacco?

Yes No If yes, \_\_\_\_\_ /day or week.

Date of last tobacco use. \_\_\_\_\_

#### Are you currently:

Pregnant	Yes	No
Depressed	Yes	No
Under stress	Yes	No

#### Have you had any of the following? X-Rays

MRI  CT Scan  EMG

If yes what were the results \_\_\_\_\_

List any medications you are currently using. \_\_\_\_\_