

RESTOR Physical Therapy @ Shoreline
 1235 Pear Ave. Suite 101
 Mountain View, CA 94043
 Phone: (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:

	<u>Self</u>		<u>Family</u>	
	Yes	No	Yes	No
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
AIDS/HIV	Yes	No	Yes	No
Hepatitis C	Yes	No	Yes	No

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 currently:

Pregnant	Yes	No
Depressed	Yes	No
Under stress	Yes	No

List any medications you are currently using. _____

Do you have a history of:

	Yes	No
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

Other medical issues: _____

Are your symptoms (check one):

Getting worse The same Improving

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. _____

Have you had any of the following? X-Rays

MRI CT Scan EMG

If yes what were the results _____

Signature: _____

Date: _____