

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

What are your weight and height? \_\_\_\_\_

Do you have any heart problems? \_\_\_\_\_

Do you have any breathing issues, like Asthma? \_\_\_\_\_

Do you have any problems with bowel or bladder control? \_\_\_\_\_

Are you experiencing vision or hearing problems? \_\_\_\_\_

Any circulation or limb problems? \_\_\_\_\_

Have you broken any bones? \_\_\_\_\_

Have you had any surgeries or medical procedures? \_\_\_\_\_

Any medical conditions, such as diabetes or bronchitis, that will affect your ability to participate in therapy? \_\_\_\_\_

Are you or could you be pregnant? \_\_\_\_\_

List any Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Circle the Activities are you having difficulty doing?

- |          |          |         |                        |
|----------|----------|---------|------------------------|
| Stairs   | Standing | Sitting | Getting Dressed        |
| Kneeling | Crawling | Walking | Getting up from Toilet |

Are you having any problems combing your hair? \_\_\_\_\_

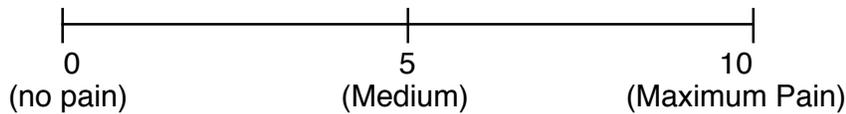
Are there any problems with driving? \_\_\_\_\_

Do you have difficulty sleeping? \_\_\_\_\_

Do you have any limitations?

- |          |          |         |
|----------|----------|---------|
| Reaching | Carrying | Lifting |
|----------|----------|---------|

If you have pain, how would you rate it on a scale of 0-10?



**HENNIKER  
PHYSICAL  
THERAPY**

*Medical History  
04/22/19*