OSPT Medical History and Systems Review

Please provide us with your medical history and pertinent background information. This information will assist your physical therapist in providing a complete and thorough evaluation.

Date: _____

Name: _____ Age: _____ Gender: F / M

Occupation: _____ Leisure Activities: _____

Describe your reason for today's visit: _____

Date of injury/Onset of problem: _____

Was the onset: gradual _____ or sudden_____

How did the problem occur? _____

Have you had any previous or similar problems? Yes or No
If yes, please explain: _____

Place a check mark if you are under the care of the following:

_____ Medical Doctor (MD) _____ Physical Therapist _____ Chiropractor
_____ Psychiatrist/Psychologist ___ Doctor of Osteopathy (DO)

If you have seen any of the above during the last three months, please describe the reason (i.e. illness, medical condition, physical exam etc.)

_____

Please list previous surgeries or any conditions for which you have been hospitalized:

Date (approx.)	Surgery/Hospitalization
_____	_____

Please describe any injuries for which you have been treated:

Date (approx.)	Injury
_____	_____
_____	_____

Have you taken any over the counter medications in the past 2 weeks?

Yes	No	Advil/Motrin/Ibuprofen
Yes	No	Antihistamines
Yes	No	Aspirin
Yes	No	Decongestants
Yes	No	Tylenol
Yes	No	Vitamins/Mineral Supplements
Yes	No	Other _____

Please go to page 2

Please list any prescription medication you are currently taking (including pills, injections, and skin patches):
1._____ 2. _____ 3. _____ 4. _____

Are you allergic to Latex? Yes or No Please list any other allergies:

1. _____ 2. _____ 3. _____ 4. _____

Have you ever been diagnosed as having any of the following conditions?

Yes No Anemia
Yes No Asthma
Yes No Cancer If so, what kind? _____
Yes No Chemical Dependency (e.g. alcoholism)
Yes No Circulation Problems
Yes No Depression
Yes No Diabetes
Yes No Emphysema
Yes No Epilepsy
Yes No Heart Problems If yes, describe _____
Yes No Hepatitis
Yes No High Blood Pressure
Yes No Kidney Disease
Yes No Multiple Sclerosis (MS)
Yes No Rheumatoid Arthritis
Yes No Other arthritic conditions _____
Yes No Stroke
Yes No Thyroid Problem If yes, describe _____
Yes No Tuberculosis
Yes No Other _____

During the past month:
Have you been feeling down or depressed? Yes or No
Have you been bothered by having little interest or pleasure in doing things? Yes or No

For Women:
Are you currently pregnant or think that you might be pregnant? Yes or No
Are you taking any fertility drugs? Yes or No

How much coffee or other caffeinated beverages do you drink per day? _____
How many packs of cigarettes do you smoke per day? _____
How many days per week do you drink alcohol? _____

Have you recently experienced:

Yes	No	Fever/Chills	Yes	No	Dizziness/Lightheadedness
Yes	No	Unexplained Weight Gain	Yes	No	Weakness
Yes	No	Fatigue	Yes	No	Numbness or Tingling
Yes	No	Nausea/Vomiting	Yes	No	Difficulty Urinating
Yes	No	Shortness of Breath			
Yes	No	Changes in Frequency of Urination	If yes, explain _____		