

MALETTA PFEIFFER & ASSOCIATES, L.L.C.
TORRINGTON PHYSICAL THERAPY

MEDICAL HISTORY FORM

Name: _____ Today's Date: _____
Date of Birth: _____ E-Mail: _____

CHIEF COMPLAINT

Why are you seeing the PT today? _____

Current problem is a result of: Car Accident Work Accident Other (Explain)

Have you ever been treated for this condition before? Yes No
By Whom? _____ When? _____

Please list any other serious illnesses _____ Age of onset _____

Please list any serious injuries _____

Please list any significant surgeries or hospitalizations and why? _____

Are you allergic to any foods or medications? Yes No If yes, please list _____

Are you allergic to latex? Yes No Have you ever had hay fever or asthma Yes No

Do you smoke? _____ Pk/day _____ Do you use drugs or alcohol? _____ Drinks/wk _____

REVIEW OF SYMPTOMS

Are you currently having or have you had any problems with:

	Circle One	Describe all <u>YES</u> responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Digestion	No Yes	_____
Bowel Movement	No Yes	_____
Bladder Problem	No Yes	_____
Diabetes	No Yes	_____
High Blood Pressure	No Yes	_____
Bleeding Problems	No Yes	_____
Balance Problems	No Yes	_____
Numbness/Tingling	No Yes	_____
Blackouts/Fainting	No Yes	_____
Psychological Problems	No Yes	_____
AIDS/HIV	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Epilepsy/Seizures	No Yes	_____
Heart Disease	No Yes	_____
Kidney Disease	No Yes	_____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____