Blankinship Physical Therapy

Medical History

Name:____ Date: ______________________

Please check any of the following conditions that apply to you.

- ❑ Asthma:________________________
- ❑ Cancer: Type:___________________
- ❑ Diabetes: Insulin? Yes No
- ❑ Seizures:_______________________
- ❑ Stroke:________________________
- ❑ High Blood Pressure:____________
- ❑ Pacemaker:_____________________
- ❑ Defibrillator:___________________
- ❑ Other:__________________________
- ❑ Pregnant:_______________________
- ❑ Osteoporosis:____________________
- ❑ Rheumatoid Arthritis:_____________
- ❑ Shingles:________________________
- ❑ Heart Disease:___________________
- ❑ Hepatitis:_______________________
- ❑ Infectious Disease________________
- ❑ Autoimmune Disease:_____________
- ❑ Recent Surgery:__________________

Please list any medication you are currently taking.

1.__________________________________

2.__________________________________

3.__________________________________

4.__________________________________

5.__________________________________

What activities are painful or difficult to do because of your injury?

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