Orthopaedic Center of Vero Beach
1285 36th Street, Suite 100
Vero Beach, FL 32960
Phone: 772.794-1234

Physical Therapy Department Patient Medical History

Are you currently working? Y N Date of last working day: ____/____/____ Date returned: ____/____/____

Have you had surgery for this case? Y N When? ___/____/____ How many? _____ Type: _____

Are you on any medications: Y N If yes, please list: _____

Are you allergic to any medications? Y N If yes, please list: _____

Do you or have you ever had any of the following?

Asthma, Bronchitis or Emphysema	Y	N	Severe or Frequent Headaches	Y	N
Shortness of Breath	Y	N	Vision or Hearing Difficulties	Y	N
Coronary Heart Disease or Angina	Y	N	Numbness and Tingling	Y	N
Do you have a Pacemaker	Y	N	Dizziness and Tingling	Y	N
High Blood Pressure	Y	N	Bowel or Bladder Problems	Y	N
Heart Attack/Surgery	Y	N	Weakness	Y	N
Stroke/TIA	Y	N	Weight Loss/Energy Loss	Y	N
Congestive Heart Failure	Y	N	Hernia	Y	N
Blood Clot/Emboli	Y	N	Varicose Veins	Y	N
Epilepsy/Seizures	Y	N	Allergies	Y	N
Thyroid Disease or Goiter	Y	N	Any Pins or Metal Implants	Y	N
Anemia	Y	N	Joint Replacement Surgery	Y	N
Infectious Disease	Y	N	Neck Injury/Surgery	Y	N
Diabetes: IDDM/NIDDM	Y	N	Shoulder Injury/Surgery	Y	N
Cancer or Chemotherapy/Radiation	Y	N	Elbow/Hand Injury/Surgery	Y	N
Arthritis	Y	N	Back Injury/Surgery	Y	N
Osteoporosis	Y	N	Knee Injury/Surgery	Y	N
Gout	Y	N	Leg/Ankle/Foot Injury/Surgery	Y	N
Sleeping Problems/Difficulties	Y	N	Are you pregnant?	Y	N
Emotional/Psychological Problems	Y	N	Do you use tobacco?	Y	N

How many alcoholic beverages do you consume per day? _____

List any other pertinent information that would assist us in your care: _____

Have you had any medical or rehabilitative services for this injury or episode? Y N _____

Are you aware of your diagnosis and prognosis as explained to you by your doctor? Y N

What are your rehabilitation goals and expectations? _____

Patient or Guardian Signature: _____ Date: ____/____/____