Blue Ridge Physical Therapy, Inc.

Brief Medical History

Name: _____ Date: _____

Nature of your illness or injury: _____

Date of onset: _____ Referring Physician: _____

Have you ever had any major surgery or injury? YES _____ NO _____

1. If "YES," what kind and when?
   Date: _____ Type: _____
   Date: _____ Type: _____
   Date: _____ Type: _____

2. Have you ever been diagnosed as having any of the following conditions?
   Yes _____ No _____ Cancer. If "Yes," describe what kind and when:
   _____
   Yes _____ No _____ Heart problems. If "Yes," describe:
   _____
   Yes _____ No _____ Do you have a pacemaker?
   Yes _____ No _____ High Blood Pressure?
   Yes _____ No _____ Diabetes?
   Yes _____ No _____ Depression?
   Yes _____ No _____ Hepatitis?
   Yes _____ No _____ Tuberculosis?
   Yes _____ No _____ Other. If "Yes," please explain:
   _____

3. Have you recently noticed:
   Yes _____ No _____ Dizziness?
   Yes _____ No _____ Numbness or tingling?
   Yes _____ No _____ Nausea or vomiting?
   Yes _____ No _____ Weight loss or gain?
   Yes _____ No _____ Fatigue?
   Yes _____ No _____ Weakness?
   Yes _____ No _____ Fever, chills or sweats?

4. Height _____ Weight _____

5. Please list all medications that you are currently taking:

Medication	Dosage	Frequency	Route of Administration

6. Do you have any skin allergies to latex, lotions, body creams, oils, etc.?
   Yes _____ No _____
7. Please list any other allergies we should know about:

   _____
8. Is there any other important information that you feel we should know about?

   _____

   _____

   _____