MIZUTA & ASSOCIATES PHYSICAL THERAPY

MEDICAL HISTORY FORM

(Please Print)

Patient's Name: _____

Is this an injury or accident case? ☐ Yes ☐ No	If yes, is there an attorney involved? ☐ Yes ☐ No
Are you currently taking any prescription or non-prescription medications?	☐ Yes ☐ No

Medication Name:	Dosage & Frequency	Method Administered:
	&	
	&	
	&	
	&	

Asthma, Bronchitis, or Emphysema	☐ Yes	☐ No	Severe or Frequent Headache	☐ Yes	☐ No
Coronary Heart Disease of Angina	☐ Yes	☐ No	Vision or Hearing Difficulties	☐ Yes	☐ No
Shortness of Breath/Chest Pain	☐ Yes	☐ No	Numbness or Tingling	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Dizziness of Fainting	☐ Yes	☐ No
Heart Attack or Heart Surgery	☐ Yes	☐ No	Bowel or Bladder Problems	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Blood Clot/Emboli	☐ Yes	☐ No	Weight Loss/Energy Loss	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Pins or Metal Implants	☐ Yes	☐ No
Infectious Diseases	☐ Yes	☐ No	Joint Replacement Surgery	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Neck Injury/Surgery	☐ Yes	☐ No
Cancer or Chemo/Radiation	☐ Yes	☐ No	Shoulder Injury/Surgery	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Elbow/Hand Injury/Surgery	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Knee Injury/Surgery	☐ Yes	☐ No
Sleeping Problems	☐ Yes	☐ No	Back Injury/Surgery	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Ankle/Foot Injury/Surgery	☐ Yes	☐ No
Emotional/Psychological Problems	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No
Do you have a pacemaker?	☐ Yes	☐ No	Do you use tobacco?	☐ Yes	☐ No

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

_____

_____

_____

_____ _____

Patient/Guardian signature *Date*