PATIENT MEDICAL HISTORY

DR. KIMBERLY WHITCHER PT, DPT | REVIVE WELLNESS PHYSICAL THERAPY

Name: _____ Date of Birth:_____

What Issues are you seeking help for from physical therapy?

_____

_____

When did it begin? _____ Is it getting: Better Worse Staying the same

Who else have you seen for this issue (check all that apply)? No one Medical Doctor Chiropractor Physical Therapist Occupational Therapist Massage Therapist Physiatrist Athletic Trainer Nutritionist Other: _____

Current work status: Full-Time Part-Time Self-Employed Unemployed Disability Retired Other_____

Do you use tobacco? Yes No If "Yes," how often? _____

How would you rate your overall health? Excellent Very Good Good Fair Poor

Are you pregnant or is there a possibility you could be pregnant? Yes No

What tests have you had?
X-Ray CT Scan MRI EMG PET Scan Ultrasound Venous Doppler Angiogram Urodynamics Cystoscopy Other_____

What surgeries have you had? (Check all that apply)

Check here if you have attached a separate sheet

Cataract	Bladder
Gallbladder	D & C
Prostate	Splenectomy
Carpal Tunnel	Appendectomy
Tonsillectomy	Breast Surgery
Hernia	Tubal Ligation
Joint	C-Section
Heart Bypass	Episiotomy
Open Heart	Hysterectomy
Skin Graft	Colon/Bowel/Intestine
Back	Kidney Thyroidectomy
Neck	

Fracture Repair and Locations:

_____

All other Pelvic or Abdominal Surgeries With Date of Operation (When Possible)

_____

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DR. KIMBERLY WHITCHER PT, DPT | REVIVE WELLNESS PHYSICAL THERAPY

Past Medical History (Check all that apply):
Check if you have attached a separate sheet

- MRSA
- Diabetes
- Hypertension
- Mitral Valve Prolapse
- Heart Attack
- Congestive Heart Failure
- DVT/Clots
- Irregular Heartbeat
- Pacemaker
- Internal Defibrillator
- Asthma
- COPD
- Emphysema
- Chronis Bronchitis
- Tuberculosis
- Frequent Heartburn
- Gastric Reflux
- Hiatal Hernia
- Cirrhosis
- Hepatitis
- Gallbladder Disease
- Stomach Ulcer
- Thyroid Disease
- Kidney Stone(s)
- Kidney Infection
- Kidney Dialysis
- Anemia
- Bruising
- HIV/AIDS
- Stroke/TIA
- Epilepsy/Seizures
- Alzheimer's
- Parkinson's Disease
- Headaches
- Restless Leg Syndrome
- Fibromyalgia
- Spinal Cord Injury
- Artificial Joint
- Arthritis
- Depression
- Anxiety
- Mental Illness
- Metal Implants
- Osteoporosis
- Vitamin Deficiency
- Other _____

Do you currently have or have you had cancer? Yes No (if "No," skip to "Allergies")

What type of cancer? _____

How is it being treated? _____

Allergies (Please list all):

_____

_____

_____

_____

_____ _____ _____

Patient/Guardian Signature Witness Signature Date