espt

orthopedics • fitness • women's health

Exercise Sport Physical Therapy

Patient Medical History

Please complete this form in its entirety.

Patient Name ______________________

Street Address ______________________

City, State & Zip ______________________

Phone # ______________________

Spouse Name ______________________

How did you com to hear about ESPT? ______________________

Age __________

D.O.B. __________

Ht. __________

Wt. __________

Never Married ☐

Married ☐

Divorced ☐

Separated ☐

Widowed ☐

HABITS

Do you smoke? ☐ # of pkgs/day ______

Do you chew? ☐ amount/day ______

Do you drink alcohol? ☐ # drinks per day ______

Do you drink caffeine? ☐ # drinks per day ______

List any other recreational substances/drugs you use:

____

Do you exercise? ______________________

Describe: ______________________

MEDICATIONS-List any medications you take regularly including over-the-counter, vitamins and/or minerals:

Name	Dosage
1.	
2.	
3.	
4.	
5.	

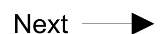
Today's date: __________

Date of last MD examination: __________

Past medical history: (please check)

Asthma	☐ Yes	☐ Family History
High Blood Pressure	☐ Yes	☐ Family History
Heart Problems	☐ Yes	☐ Family History
Neurologic Disorders	☐ Yes	☐ Family History
Pacemaker	☐ Yes	☐ Family History
Stroke	☐ Yes	☐ Family History
Osteoporosis	☐ Yes	☐ Family History
Blood Clots	☐ Yes	☐ Family History
Diabetes	☐ Yes	☐ Family History
Cancer	☐ Yes	☐ Family History
Seizures	☐ Yes	☐ Family History
Tuberculosis	☐ Yes	☐ Family History
Birth Defects	☐ Yes	☐ Family History
Osteoarthritis	☐ Yes	☐ Family History
Are you pregnant?	☐ Yes	☐ No

Other ______________________

Next 

ALLERGIES- Are you allergic to the following? (Please check)

☐ Yes ☐ No **Drugs- list** ____________________

☐ Yes ☐ No **Food- list** ____________________

☐ Yes ☐ No **Latex**

☐ Yes ☐ No **Environmental**

☐ Yes ☐ No **Other- describe**

To be completed by ESPT staff:

Initials ____________________

Date ____________________

Next ⟶

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Patient & Family Medical History

Patient Name: ____________________

Patient DOB: ____________________

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us:

Condition	I Had	When	Family (Specify Relationship)
Arthritis	☐		
Sciatica	☐		
Back Problems	☐		
Neck Problems	☐		
Sprain/Strain	☐		
Headaches	☐		
Hand Problems	☐		
Jaw Pain	☐		
Shoulder Pain	☐		
Knee Pain	☐		
Hip Pain	☐		
Ankle Pain	☐		
Osteoporosis	☐		
Balance Issues/Falls	☐		

Other	I Had	When	Description
Surgery (Shoulder/Elbow/Hand)	☐		
Surgery (Hip/Knee/Ankle)	☐		
Surgery (Neck/Back)	☐		
Pregnancy/Delivery (ies)	☐		
Motor Vehicle Accident w/Injury	☐		

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Please describe any additional medical issues not addressed above.

How is this issue affecting you in the areas listed below:

Financially: ______________________________

Emotionally: ______________________________

Socially: ______________________________