# PERTINENT MEDICAL HISTORY

Patient Name_____ Date_____

| DO YOU HAVE A HISTORY OF: | YES | NO | REMARKS | DATE OF ONSET |
|---|---|---|---|---|
| High blood pressure | | | | |
| Heart disease | | | | |
| Diabetes | | | | |
| Respiratory Problems | | | | |
| Cancer | | | | |
| Broken bones | | | | |
| Other | | | | |

| DO YOU HAVE: | YES | NO | REMARKS | DATE OF ONSET |
|---|---|---|---|---|
| A Pacemaker | | | | |
| Metal Implants | | | | |
| Are You Pregnant? | | | | |

PLEASE LIST ANY SURGERIES YOU HAVE HAD AND THE DATES OF THOSE SURGERIES:

IF YOU ARE ON ANY MEDICATION, PLEASE LIST THEM BELOW:

DO YOU HAVE ANY ALLERGIES? YES / NO
IF "YES", PLEASE EXPLAIN:

DO YOU HAVE ANY OTHER MEDICAL PROBLEM
NOT LISTED ABOVE? YES / NO
IF YES, PLEASE EXPLAIN AND PROVIDE DATE OF ONSET:

IN CASE OF EMERGENCY CONTACT:_____PH#_____
RELATIONSHIP:_____

Patient Signature_____Date_____

Therapist Signature_____Date_____