Medical History Form

Patient Name: ____ DOB: ________________

MEDICAL HISTORY (Please describe any "yes" answers in the box below)

Condition		Condition		Condition	
Abnormal Blood Pressure	O Yes O No	Diabetes	O Yes O No	Metal Implants	O Yes O No
Allergies	O Yes O No	Dizzy Spells	O Yes O No	MRSA	O Yes O No
Anemia	O Yes O No	Emboli/Blood Clots	O Yes O No	Multiple Sclerosis	O Yes O No
Anxiety	O Yes O No	Emphysema/Bronchitis	O Yes O No	Muscular Disease	O Yes O No
Arthritis	O Yes O No	Fibromyalgia	O Yes O No	Osteoporosis	O Yes O No
Asthmas	O Yes O No	Fractures	O Yes O No	Parkinson's Disease	O Yes O No
Autoimmune Disorder	O Yes O No	Gallbladder Problems	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cancer	O Yes O No	Headaches	O Yes O No	Seizures	O Yes O No
Cardiac Conditions	O Yes O No	Hearing Impaired	O Yes O No	Smoking	O Yes O No
Cardiac Pacemaker	O Yes O No	Hepatitis	O Yes O No	Speech Problems	O Yes O No
Chemical Dependency	O Yes O No	High Cholesterol	O Yes O No	Strokes/TIA	O Yes O No
Chest Pain/Short of Breath	O Yes O No	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Circulation Problems	O Yes O No	Infectious Disease	O Yes O No	Tuberculosis	O Yes O No
Currently Pregnant/Trying	O Yes O No	Incontinence-Bladder/Bowel	O Yes O No	Vision Problems	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No		

MARITAL STATUS: Married Divorced Widow Single Other

OCCUPATION/STUDENT STATUS (specify full/part time): ____

FALLS HISTORY Current injury is a result of a fall in the past year: O Yes O No Date of fall: ______________________

Two or more falls in the last year?: O Yes O No Dates of falls: ____

SURGICAL HISTORY (please list additional surgeries on back of sheet)

Body Region: ______________________ Surgery Type: ______________________ Date (mm/dd/yyyy): ____________________
Body Region: ______________________ Surgery Type: ______________________ Date (mm/dd/yyyy): ____________________
Body Region: ______________________ Surgery Type: ______________________ Date (mm/dd/yyyy): ____________________

CURRENT MEDICATIONS (please list additional medications on back of sheet)

Drug: ___________________________ Dosage: ___________________________ Frequency: ______________________________
Reason for Taking: ________________________ How do you take this medication: ____________________________________

Drug: ___________________________ Dosage: ___________________________ Frequency: ______________________________
Reason for Taking: ________________________ How do you take this medication: ____________________________________

Drug: ___________________________ Dosage: ___________________________ Frequency: ______________________________
Reason for Taking: ________________________ How do you take this medication: ____________________________________

I hereby agree & give my consent to medical treatment in treating my physical condition. I give consent to Chautauqua Physical & Occupational Therapy (CPT) to use & disclose my protected health information with my referring physician & for purposes of treatment & payment. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes in my insurance. I authorize release of payment directly to CPT regardless of participation in or out-of-network. Should I default on my financial responsibility & collection action is necessary, I will be responsible for collection costs that are incurred. I give CPT permission to leave a message on my answering phone or with another party. I also give CPT permission to discuss my medical condition with another party. You have the right to review our posted Privacy Policy before you sign this consent. CPT reserves the right to amend the terms of our Privacy Policy at any time. I agree to & understand all of the above information.

Emergency Contact: _________________________________ Phone: ______________________ Relation: _____________

Patient/Parent/Guardian Signature: ____ Date: _______________

Email Address: ____