HEALTH HISTORY (Confidential)

Today's Date ____________________

Patient Name ________________ **Age** ________ **Date of Birth** ____________________

Reason for your visit today ____

Symptoms: Check symptoms you currently have or have had in the past.
Please provide approximate dates for any checked responses.

Heart Disease	**Date**
❑ Congestive Heart Failure	________
❑ High Blood Pressure	________
❑ Heart Attack (Myocardial Infarction)	________
❑ Atherosclerotic Disease (CAD)	________
❑ Angioplasty	________
❑ Valvular Disease	________
❑ Stents	________
❑ Arrhythmia	________
❑ Coronary Artery Bypass Graft (CABG)	________
❑ Angina	________

Vascular Disease	
❑ Peripheral Arterial Disease	________
❑ Acquired Respiratory Distress Syndrome (ARDS)	________
❑ Diabetes	________
❑ Taking Blood Pressure Meds	________
❑ Stoke/ TIA	________
❑ Chronic Bronchitis	________
❑ Hypertension	________

Lung Disease	
❑ Chronic Obstructive Pulmonary Disease (COPD)	________
❑ Emphysema	________
❑ Asthma	________
❑ Recent Pneumonia	________

General Medical Conditions	**Date**
❑ Arthritis (rheumatoid/osteoarthritis	________
❑ Allergies	________
❑ Neurological Disease (such as MS or Parkinson's)	________
❑ Headaches	________
❑ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	________
❑ Visual impairments (cataracts, glaucoma, macular degeneration)	________
❑ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)	________
❑ Hepatitis/ AIDS	________
❑ Osteoporosis	________
❑ Anxiety or Panic Disorders	________
❑ Depression	________
❑ Previous Accidents	________
❑ Kidney, Bladder, Prostrate or Urination Problems	________
❑ Incontinence	________
❑ Hearing Impairment- very hard of hearing, even with hearing aide	________
❑ Sleep Dysfunction	________
❑ Prosthesis/ Implants	________
❑ Cancer	________
❑ Physical Therapy at another facility this calendar year	

Other Disorder- please describe

____

____

____