Reynolds & Associates
Physical Therapy, Inc.

PATIENT HISTORY

In order to provide you the best care, it is beneficial to know as much about your health history as possible. Please complete this form to the best of your knowledge. Thank you.

Patient's Name**:**_____ DOB**:**_____ Age: _____ Date**:**_____

Occupation**:**_____ Currently Working? ___Yes ___No

Past Medical History CHECK ALL THAT APPLY:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina or Chest Pain
- ☐ Arthritis/Gout
- ☐ Asthma/Hay Fever
- ☐ Cancer Type: _____
- ☐ Chronic Bronchitis
- ☐ Cirrhosis/Liver Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Heart Disease
- ☐ Hepatitis/Jaundice
- ☐ Hypo / Hyper glycemia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease/Stones
- ☐ Latex Allergies
- ☐ Migraine Headaches
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic/Scarlet Fever
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Reflux/GERD
- ☐ Ulcers/Stomach Problems
- ☐ Urinary Tract Infection

Other_____

Please list **ALL** known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements you are taking. Medicare requires that this list contain the medications' name, dosages, frequency and route of administration (i.e. oral, sublingual, topical, nasal, inhaled, injection, subcutaneous).
We can copy a detailed list if you have one.

NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

PLEASE CONTINUE TO PAGE 2

Please list any x-rays, or other imaging studies you have had related to this condition and the date(s) performed.

DESCRIPTION	**WHERE DONE**	**DATE**

Please list any surgeries that you have had and the date(s) performed.

SURGERY	**WHERE DONE**	**DATE**

Have you had 2 or more falls within the past 12 months?	Yes □	No □
Have you had any fall resulting in injury within the past 12 months?	Yes □	No □
Do you experience episodes of dizziness?	Yes □	No □
Have you noticed any lumps/thickening of skin/muscle anywhere on your body?	Yes □	No □
Have you had any unexplained weight loss in the last month?	Yes □	No □
Do you exercise regularly?	Yes □	No □
Do you have any difficulty sleeping?	Yes □	No □
Do you have difficulty swallowing?	Yes □	No □