BRAUN
PHYSICAL THERAPY

**PATIENT MEDICAL HISTORY**

Name _____ Date of Birth _____ Age _____
Occupation _____ Full-time/part-time/retired

In general, would you say your overall health right now is…?
◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

Do you now, or have you ever had, problems with the following…

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Falls | ☐ | ☐ | Allergy to Cold | ☐ | ☐ | Pins & Needles | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Other Allergies | ☐ | ☐ | Bowel/ Bladder Changes | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Night Sweats | ☐ | ☐ | Unexplained Night Pain | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Previous Surgery | ☐ | ☐ | Circulatory Problems | ☐ | ☐ |
| Chronic Headaches | ☐ | ☐ | Seizures | ☐ | ☐ | Persistent Fevers | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ | Metal Implants | ☐ | ☐ | Sleep Issues | ☐ | ☐ |
| Nervous Disorders | ☐ | ☐ | Dizziness | ☐ | ☐ | Fractures | ☐ | ☐ |
| Hernia | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Allergy to Heat | ☐ | ☐ | Pregnant | ☐ | ☐ | Problems with both Arms | ☐ | ☐ |
| Bone Disease | ☐ | ☐ | Osteoporosis | ☐ | ☐ | & Legs at the Same Time | | |

If YES to any of the above, please explain and give details: _____
_____
_____
_____

Are you presently taking any medications? YES ☐ NO ☐
If YES, please list your medications and for what condition: _____
_____

Is there anything else we should know about your general health, or current condition? Please explain and, if necessary, we can talk about it: _____
_____

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