Lago Vista Physical Therapy
5802 Thunderbird St. Suite A
Lago Vista, TX 78645
Phone: (512) 267-5400 Fax:(512) 267-5700

Medical History Form

Patient Name: _____ Date of Birth: ___/___/___ Date of Injury: ___/___/___
To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any further questions please ask for assistance.

Please Circle any condition for which you have received treatment for:

High Blood Pressure	Heart Murmur	Asthma Recent	Weight Loss/Gain
Heart Problem	Chronic Lung	Diabetes	Abnormal Bleeding
Abnormal Heart Rate	Chronic Heart Burn	Osteoporosis	Allergies(_____)
Pace Maker	History of Ulcers	Cancer(_____)	
Heart Palpitations	High Cholesterol	Epilepsy/Seizure	

Other:_____.

Have you fallen within the last year? Yes No

If yes, how many times: _____, Were you injured in the fall? Yes or No If yes, what body part was hurt: _____

Do you have a history of fractures? Yes No Where?_____

Do you have a history of back/neck pain? Yes No When? _____

Do you have any metal implants? Yes No Where? _____

Do you smoke? Yes No How often? _____

Do you exercise regularly? Yes No How often? _____

In regards to your current condition today:

Do you have any "pins and needles" or numbness in your extrmities? Yes No

Do you have any weakness in your arms or legs? Yes No

Do you have any coordination or balance problems? Yes No

Do you experience dizziness or vertigo with change in position? Yes No

Have you experienced headaches as a result of your condition? Yes No

Were you injured in a work related accident? Yes No

Were you injured in a car related accident? Yes No

Please list any current medications: _____

_____

Please list all surgeries and dates: _____

What do you hope to achieve with skilled physical therapy intervention? _____

Patient Signature:_____Date:___/___/___.