



This form can be completed on your computer, or printed and fill in by hand.

RYE PHYSICAL THERAPY & REHABILITATION
Medical History and Systems Review

Name _____ Birth Date _____ Date _____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Surgery/Hospitalization/Reason
_____	_____
_____	_____
_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains, strains) and the approximate date of injury:

Date	Injury
_____	_____
_____	_____
_____	_____

Please list any PRESCRIPTION or over-the-counter medication, vitamins/supplements that you are currently taking (including pills, injections and/or skin patches):

Have you or any of your family EVER been diagnosed as having any of the following:

YOU FAMILY

Cancer	YES
If YES, describe what kind: _____	
Heart Problems	YES
High Blood Pressure	YES
Asthma	YES
Emphysema	YES
Chemical Dependency (e.g. alcoholism)	YES
Thyroid Problems	YES
Diabetes	YES
Multiple Sclerosis	YES
Rheumatoid Arthritis	YES
Other Arthritic Condition	YES
Depression	YES
Hepatitis	YES
Tuberculosis	YES
Stroke	YES
Kidney Disease	YES
Anemia	YES
Epilepsy	YES
Are you Currently Pregnant?	YES
Osteopenia/Osteoporosis	YES
Other _____	YES

Date of last complete physical exam: Month _____ Year _____ Physician _____

RYE PHYSICAL THERAPY & REHABILITATION

Name: _____

Date: _____

HAVE YOU HAD, OR DO YOU EXPERIENCE:

Cardiovascular System

YES NO

- Elevated cholesterol
- Sweating associated with pain
- Palpitations
- Swelling of extremities
- History of Smoking
- Orthopnea (difficulty breathing)

GI System

YES NO

- Difficulty swallowing
- Heartburn
- Jaundice (yellow appearance)
- Specific food intolerance
- Constipation
- Diarrhea
- Change in color of stool
- Rectal bleeding
- Gall bladder problems
- Liver Problems

G.U. System

YES NO

- Dysuria (painful urination)
- Hematuria (blood in urine)
- Incontinence
- Frequency of urination
- Urinary urgency
- Vaginal discharge
- Dysmenorrhea
(painful menstruation)
- Post menopausal vaginal bleeding
- Painful intercourse
- Infertility
- History of STD
- Date of Last Period ___/___/___

Pulmonary System

YES NO

- Dyspnea (labored breathing)
- Wheezing
- Prolonged Cough
- Sputum production
amount/color: _____

Endocrine System

YES NO

- Excessive thirst
- Excessive hunger
- Polyuria (large volume of urine)
- Excessive sweating
- Fatigue
- Weakness
- Thyroid problems

Neurological System

YES NO

- Ataxia (poor muscular coordination)
- Memory Lapses
- Confusion
- Head Trauma
- Neurological disorder
- Tremors
- Slurred speech patterns
- Hearing/Visual disturbances

Other Systems

YES NO

- ENT (ears, nose, throat)
- Integumentary (skin)
- Lymphatic
- Psychiatric
- Musculoskeletal