

**DENTON SPORTS & PHYSICAL THERAPY CENTER
PERSONAL MEDICAL HISTORY**

Patient Name: _____

Do you or have you had any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcer/Stomach problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Seizures-convulsions | <input type="checkbox"/> Arthritis-Rheumatism |
| <input type="checkbox"/> Communicable Diseases | <input type="checkbox"/> Mental illness (i.e., depression, anxiety, etc) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Circulation disorders |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Surgery (Please list type and year) | <input type="checkbox"/> Allergies to medications _____ |
| _____ | <input type="checkbox"/> Other allergies _____ |
| _____ | _____ |

Please list other ailments not listed above? _____

What prescription medications are you taking, if any? _____

What over-the-counter supplements/medications are you taking, if any? (Include all vitamins, supplements, herbs): _____

During this current calendar year, have you had any rehabilitation from a medical professional (chiropractor, D.O, etc.) such as heat/cold packs, ultrasound, manipulation, massage, etc? ___ Yes ___ No

If yes, please state the condition: _____

Approximate number of visits this year _____