PATIENT INITIALS:_____ CONROY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY

PATIENT HISTORY FORM

Describe the history of your problem, including date and description of injury or onset:

_____
_____
_____
_____
_____
_____
_____(over)

Please list any doctors you have seen in order.

Doctors seen:	Date:	Treatment:	Test:(x-ray, MRI, EMG)

Please list any and all medications you are currently taking. This should include prescriptions, vitamins, mineral/herbal supplements, topical creams/ointments and over-the-counter medications.

Name of medication	Dose	Route (oral, topical, injection)	Frequency

Alllergies:_____

Adverse drug reactions:_____

PATIENT HISTORY PG. 2

Please list any previous surgeries or medical conditions:

Surgery:	Date:

Please list significant accidents/injuries/hospitalizations:

Incident:	Date:

Please indicate family history of the following, including mother(M), father(F), sibling(S), grandparent(G) or child(C):

Cancer:	High Blood Pressure:	Respiratory Problems:
Diabetes:	Kidney Disease:	Liver Disease:
Heart Disease:	Stroke:	Seizures:

At the present time, would you say your health is:

___Excellent ___Very Good ___Fair ___Poor