OTTAUQUECHEE PHYSICAL THERAPY SERVICES
Peter P. Mayock, P.T., Clinical Director

MEDICAL HISTORY FORM

NAME_____**DATE**_____

***** Please check any condition for which you have a current or post medical history:

___Diabetes	___Asthma
___Seizures	___Poor Circulation or
___Hypoglycemia	___Peripheral Vascular Disease
___Heart Disease	___Stroke
___Lung Disease	___High Blood Pressure

* If you are female, are you or could you now be pregnant? _____Y_____N

* Do you have a pacemaker? _____Y_____N

* Are you currently taking any medication? _____Y_____N
If yes, please list the name(s) and purpose(s)_____
_____
_____

* Do you have any exercise precautions? _____Y _____N
If yes, please list the physician_____
The nature of the restrictions _____
_____

* Please list the injury of condition / ailment for which you are being treated:_____
_____

* Have you even been hospitalized or had surgery as a result of this?
If yes, please list the physician:_____
Hospital:_____
Date: _____

* Do you have any other medical problems or conditions not previously mentioned on this form? _____
_____
_____

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN DATE