

BRONX PHYSICAL THERAPY

MEDICAL INFORMATION

Name: _____ Date: _____
Family Physician: _____ Phone: _____
Address: _____ City/State/Zip: _____

PLEASE ANSWER THE FOLLOWING:

Do you presently have, or, have you ever had:

- Diabetes?Type I ___ Type II ___Yes ___ No ___
Hepatitis?Yes ___ No ___
High Blood Pressure?Yes ___ No ___
If yes, is it controlled?.....Yes ___ No ___
Difficulty Breathing or Lung problems?Yes ___ No ___
Cancer?Yes ___ No ___
Abdominal pain (prolonged)?Yes ___ No ___
Allergies to Medication?Yes ___ No ___
Abnormal heart Condition?Yes ___ No ___
If yes, Do you have a Pacemaker?Yes ___ No ___
Infectious disease?Yes ___ No ___
Sensitivity to heat or cold?Yes ___ No ___
Headaches (persistent)?Yes ___ No ___
Lasting or prolonged pain?Yes ___ No ___

If yes, what area of the body? _____

Presently Pregnant?Yes ___ No ___

IF YOU ANSWERED YES TO ANY OF THE ABOVE , EXPLAIN HERE _____

Are you taking medication now?Yes ___ No ___

If yes, for what reason? _____

List medications presently taking: _____

Has a physician ever prescribed steroids for you? (prednisone)Yes ___ No ___

Has physician ever instructed you to limit your activity?

If yes, how? _____

Do you have limitations to exercise?

If yes, explain: _____

Do you have a DO NOT RESUSITATE (DNR) order in effect?.....Yes ___ No ___

Signature: _____ Date: _____