SKYLINE PHYSICAL THERAPY SERVICES
MEDICAL HISTORY FORM

Existing Conditions

Check all that apply to you

Allergies ◯	**Hepatitis** ◯
Anemia ◯	**High Cholesterol** ◯
Anxiety ◯	**High/Low Blood Pressure** ◯
Arthritis ◯	**Incontinence** ◯
Asthma ◯	**HIV/AIDS** ◯
Autoimmune Disorder ◯	**Kidney Problems** ◯
Cancer ◯	**Metal Implants** ◯
Cardiac Conditions ◯	**MRSA** ◯
Cardiac Pacemaker ◯	**Multiple Sclerosis** ◯
Chemical Dependency ◯	**Muscular Disease** ◯
Circulation Problems ◯	**Osteoporosis** ◯
Currently Pregnant ◯	**Parkinsons** ◯
Depression ◯	**Rheumatoid Arthritis** ◯
Diabetes ◯	**Seizures** ◯
Dizzy Spells ◯	**Smoking** ◯
Emphysema/Bronchitis ◯	**Speech Problems** ◯
Fibromyalgia ◯	**Strokes** ◯
Fractures ◯	**Thyroid Disease** ◯
Gallbladder Problems ◯	**Tuberculosis** ◯
Headaches ◯	**Vision Problems** ◯
Hearing Impairment ◯	

Describe any other conditions that are not specified above.

_____
_____
_____

Fall History

◯ Injury as a result of a fall in the past year?

◯Two or more falls in the last year?

Surgical History

Please state what surgeries you have had as well as the date they were done.

_____
_____
_____
_____
_____
_____
_____

Current Medications

Please list all medications you are currently taking, the dosage, frequency, route, and reason for taking it.

_____
_____
_____
_____
_____
_____
_____
_____