MEDICAL HISTORY FORM
SUNSHINE PHYSICAL THERAPY CLINIC

1705 17TH AVENUE
VERO BEACH, FL 32960

Telephone (772)562-6877
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NAME: _____ DATE: _____

DATE OF INJURY OR WHEN YOU FIRST EXPERIENCED YOUR SYMPTOMS: _____

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF YES, **PLEASE EXPLAIN:**

CONDITION	YES	NO	COMMENTS
HEART DISEASE	☐	☐	
CANCER	☐	☐	
DIABETES	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
ASTHMA OR LUNG DISEASE	☐	☐	
PACEMAKER	☐	☐	
FRACTURES	☐	☐	
OSTEOPOROSIS	☐	☐	
METAL IMPLANTS	☐	☐	
MAJOR SURGERY	☐	☐	
BACK/NECK PAIN OR INJURY	☐	☐	
KNEE PROBLEMS	☐	☐	
DIZZINESS/FAINTING SPELLS	☐	☐	
ALLERGIES	☐	☐	
SKIN DISORDERS/RASHES	☐	☐	
PREGNANT (PRESENTLY)	☐	☐	
VISUAL/HEARING DIFFICULTY	☐	☐	
SEIZURES	☐	☐	
INFECTIOUS DISEASES (TB, HEPATITIS B, HIV/AIDS)	☐	☐	
ANY CONDITIONS NOT MENTIONED ABOVE	☐	☐	

COMMENTS: _____

PLEASE LIST ALL **MEDICATIONS** (PRESCRIPTION AND NON-PRESCRIPTION) THAT YOU ARE PRESENTLY TAKING, THE DOSAGE, AND HOW LONG YOU HAVE BEEN TAKING IT.

MEDICATION	DOSAGE	DURATION

To the best of my knowledge, I have no other active diseases or illnesses at this time.

_____

Signature **Date**