GREAT DIVIDE
PHYSICAL THERAPY

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GENERAL MEDICAL HISTORY

NAME: _____ **DATE:** _____

Have you recently noticed any of the following (please check all that apply):

☐ Fatigue	☐ Numbness or tingling	☐ Fever/chills/sweats
☐ Muscle weakness	☐ Nausea/vomiting	☐ Dizziness/lightheadedness
☐ Shortness of breath	☐ Weight loss or gain	☐ Heartburn/indigestion
☐ Fainting	☐ Falls	☐ Headaches
☐ Difficulty in maintain balance while walking		☐ Difficulty swallowing
☐ Changes in bowel or bladder function		

Have you ever been diagnosed with any of the following conditions (please check all that apply):

☐ Heart problems	☐ Stroke	☐ Cancer
☐ Liver problems/Hepatitis	☐ Lung problems	☐ Diabetes
☐ Gall bladder problems	☐ Tuberculosis	☐ Osteoporosis
☐ High blood pressure	☐ Asthma	☐ Multiple Sclerosis
☐ Circulation problems	☐ Rheumatoid arthritis	☐ Epilepsy / Seizures
☐ Ulcers/stomach problems	☐ Migraines	☐ Vision Problems
☐ Bladder/urinary tract infections	☐ Pneumonia	☐ Anemia
☐ Kidney problems/infections	☐ Parkinson's disease	☐ Thyroid problems
☐ Chemical Dependency	☐ Depression	☐ Other _____

Are you latex sensitive? ☐ Yes ☐ No
Do you smoke or use tobacco products? ☐ Yes ☐ No
(For Women) Are you currently pregnant or do you think you may be pregnant? ☐ Yes ☐ No

Have you been injured as the result of a fall in the past year? ☐ Yes ☐ No
Have you had two or more falls during the past year? ☐ Yes ☐ No

Please list any major surgeries you have had: _____
_____
_____
_____