Medical History

Primary Care Physician's Name _____ Phone _____

1.Please list any past serious illnesses or operations:

_____

_____

2. Are you currently taking any medications? ◊ YES ◊ NO

Please describe: _____

3. Do you smoke? ◊YES ◊NO 4. Do you use alcohol? ◊ YES ◊NO

5. Do you use other drugs? ◊ YES ◊NO

6. Are you allergic to: ◊latex ◊ aspirin/NSAIDs ◊topical ointments ◊Other _____

7. (Women only) Are you currently pregnant? ◊YES ◊NO

Do **YOU** or have **YOU** ever had the following:

Anemia (low blood count)....	◊YES ◊NO	Anorexia.....	◊YES ◊NO
Asthma.....	◊YES ◊NO	Bleeding Disorder.....	◊YES ◊NO
Cancer.....	◊YES ◊NO	Chemical Dependency.....	◊YES ◊NO
Chemotherapy.....	◊YES ◊NO	Chronic Fatigue Syndrome.....	◊YES ◊NO
Circulatory Problems.....	◊YES ◊NO	Diabetes.....	◊YES ◊NO
Emphysema.....	◊YES ◊NO	Epilepsy.....	◊YES ◊NO
Glaucoma.....	◊YES ◊NO	Heart Disease.....	◊YES ◊NO
Hepatitis-Type____.....	◊YES ◊NO	Hernia-Type_____	◊YES ◊NO
Herpes.....	◊YES ◊NO	High Blood Pressure.....	◊YES ◊NO
HIV/AIDS.....	◊YES ◊NO	Jaundice.....	◊YES ◊NO
Kidney Problems.....	◊YES ◊NO	Liver Disease.....	◊YES ◊NO
Low Blood Pressure.....	◊YES ◊NO	Multiple Sclerosis.....	◊YES ◊NO
Osteoporosis.....	◊YES ◊NO	Osteoarthritis.....	◊YES ◊NO
Pacemaker.....	◊YES ◊NO	Polio.....	◊YES ◊NO
Psychiatric Care.....	◊YES ◊NO	Prostate Problem.....	◊YES ◊NO
Respiratory Disease (COPD)...	◊YES ◊NO	Stroke.....	◊YES ◊NO
Thyroid Problem.....	◊YES ◊NO	Ulcer.....	◊YES ◊NO

◊Other (please describe):_____

_____

Assignment and Release

I hereby authorize payment directly to O'Brien Physical Therapy for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____Date _____