BATON ROUGE PHYSICAL THERAPY
IN PARTNERSHIP WITH OUR LADY OF THE LAKE

MEDICAL HISTORY

Check any of the following problems that apply to you:

❒ Arthritis	❒ Hearing impairment (very hard of hearing, even with hearing aids)
❒ Osteoporosis	❒ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
❒ Asthma	❒ Kidney, bladder, prostate, or urination problems
❒ Chronic obstructive pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema	❒ Previous accidents: **LIST TYPE / DATE**
❒ Angina	❒ Incontinence
❒ Congestive heart failure or heart disease	❒ Anxiety or panic disorders
❒ Heart attack (myocardial infarction)	❒ Depression
❒ High blood pressure	❒ Other disorders: **LIST**
❒ Neurological disease (Multiple Sclerosis or Parkinson's)	❒ Hepatitis ❒ Tuberculosis
❒ Alzheimer's	❒ AIDS ❒ Epilepsy
❒ Stroke or TIA	❒ Sleep dysfunction
❒ Peripheral vascular disease (or claudication)	❒ Cancer
❒ Headaches	❒ Recent / unexplained weight gain or loss
❒ Diabetes Type I or II	❒ Nausea / dizziness
❒ Gastrointestinal disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	❒ Other conditions / injuries: **LIST**
❒ Visual impairment (cataracts, glaucoma, macular degeneration)	

About you: ❒ **Right** handed or ❒ **Left** handed Currently pregnant? ❒ **No** ❒ **Yes** Tobacco user? ❒ **No** ❒ **Yes**

Metal implants? ❒ **No** ❒ **Yes – where?**_____ Pacemaker? ❒ **No** ❒ **Yes** Height:_____ Weight:_____lbs

Surgeries: ❒ **None** ❒ **Yes - -** List type & date:

Medications: ❒ Over-the-counter pain meds ❒ Prescription pain meds ❒ Anti-inflammatory ❒ Muscle relaxant
❒ Aspirin/blood thinners ❒ Long-term use of corticosteroids

Are you taking a **Statin Cholesterol** medicine such as the following?
❒ **No** ❒ **Yes - -** Circle your response: **Lipitor / Simvastatin (Zocor) / Mevacor**

List all **other medications**: ❒ **See attached medication list**

Have you taken the following **antibiotics** in the past year?
❒ **No** ❒ **Unknown** ❒ **Yes - -** Circle your responses: **Cipro / Levaquin / Floxcin / Noroxin / Vigamax / Avelor**

Is this **current condition the result of an injury/accident**? ❒ **No** ❒ **Yes** - **If yes**, date of injury/accident:_____

Previous therapy for this condition? ❒ **No** ❒ **Yes – when?**_____ **where?** _____

List known **allergies**: ❒ **None** ❒ **Yes - -** List type & your reaction to irritant:

_____ **Patient Name (print)** _____ **Patient DOB**

MEDICAL HISTORY (continued)

How many times have you fallen in the past 12 months?_____ Did it result in an injury? ❒ **No** ❒ **Yes**

During the past month, have you been **feeling down, depressed, or hopeless or bothered by having little interest or pleasure** in doing things? ❒ **No** ❒ **Yes**

With whom do you live:

☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child(ren) ☐ Parents ☐ Other:_____

Where do you live:

☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other:_____

Does your home have:

☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain

Please explain:_____

Employment/Work (Job/School/Play):

Working: ☐ Full time ☐ Part time - - Occupation_____ ☐ Retired ☐ Unemployed ☐ Student

Pain Rating:

If you have pain, what is your pain level? Circle.

CURRENT Pain

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst possible pain

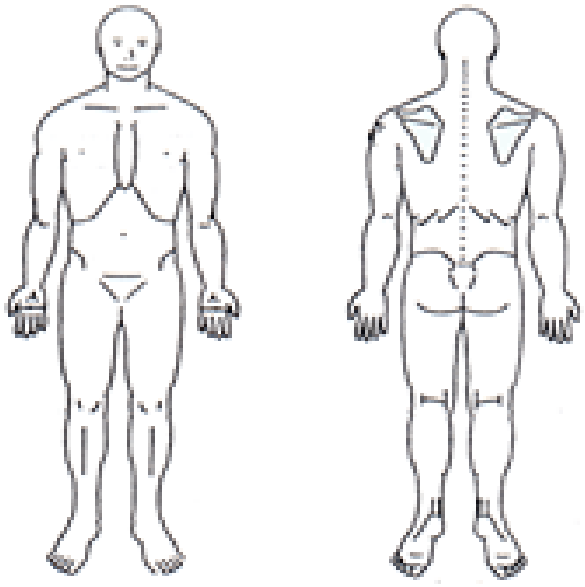
Pain level at **BEST**

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst possible pain

Pain level at **WORST**

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst possible pain

Please mark your symptoms on the body diagrams:



brptlake#162; Rev. 8-15-2019

To the best of my knowledge, the above information is accurate and complete.

Patient Name (print) **Patient DOB** **Date**

Patient (or Representative) Signature **Representative's Name (print)**

Therapist Signature **Date**