PRIME Physical Therapy

1161 NE Rice Rd
Lee's Summit, MO 64086
P) 816-402-2178

Medical History Form

Patient Name:	**Date of Next Doctor's Appt:**
Chief complaint of Visit:	**Onset Date:**
Give us your goal of physical therapy treatment (outcome of therapy):	
Any Allergies including Medication (Specify):	
Current Medications for all Medical Conditions (or Provide List):	

Have you or will you receive any of the following tests because of this problem? (Please circle all that apply):
X-ray EMG/NCS MRI CT Scan VEMP BAEP (hearing test) VNG Rotary Chair Caloric Test
Other tests: _____
*(*EMG: Electromyography *NCS: Nerve Conduction Study *VEMP: Vestibular Evoked Myogenic Potential*
**BAEP: Brainstem Auditory Evoked Potential) *VNG: Videonystagmography)*

Result of Tests:

Personal Medical History (Current: "C" or Past: "P" – Please specify):

____Tobacco's use	____Cancer/Tumor	____Kidney Problems
____Lung Problems	____Osteoarthritis	____Tuberculosis (TB)
____Heart Conditions (specify:_____)	____Rheumatoid Arthritis	____ High Blood Pressure
____Pacemaker/ICD device	____Osteoporosis	____Low Blood Pressure
____ Stroke (CVA)	____ Head Injury (TBI or Concussion)	____ Migraine/Headache
____Blood Clots/DVT	____Metal Implants	____Fibromyalgia
____Rheumatic Fever	____Seizures/Convulsions	____Lupus (SLE)
____Aneurysm	____Changes in bowel or bladder	____Hepatitis
____Diabetes (Inject Insulin Yes/No)	____Frequent Nausea/Vomiting	____Gout
____Frequent Depression	____Poor Circulation	____Poor eyesight/hearing
____Fainting/Dizzy/Lightheaded	____Trouble swallowing or speaking	____Frequent swelling
____Peripheral Neuropathy	____Multiple Sclerosis (MS)	____Parkinson's Disease
____HIV/ADIS	____ Others (Please Specify): _____	

Work Status
Employer: _____ Occupation: _____
☐ Full Time ☐ Full time with restrictions ☐ Part Time ☐ Part time with restrictions ☐ Off Work
☐ Retired ☐ Disabled ☐ Other: _____

Other General Health:
Have you had a recent unexplained weight loss or gain (more than 10lbs in the last few months)? ☐ Yes ☐ No

Have you ever been threatened or otherwise harmed by your spouse, partner, any family member, or neighbor? ☐ Yes ☐ No If yes, would you like to speak confidentially to a Domestic Violence Advocate? ☐ Yes ☐ No

_____/_____/_____/_____
Patient/Guardian Signature Date Time Therapist's Signature