PATIENT HISTORY continued

Family History
"(Indicate whether mother, father, brother/sister, aunt/uncle" or grandmother/grandfather and age of onset, if know)"

Heart disease _____
Hypertension _____
Stroke _____
Diabetes _____
Cancer _____
Lymphedema _____
Other _____

Medical tests within the last few years: (check all that apply)

- ☐ ABI
- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ Bronchoscopy
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ Lymphscintigraphy
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (nerve conduction velocity)
- ☐ Pap smear
- ☐ Pulmonary function test
- ☐ Spinal tap
- ☐ Stool tests
- ☐ "Stress test (eg: treadmill, bicycle)
- ☐ Urine tests
- ☐ X-rays

Past Medical History
Please check if you have ever had:

- ☐ Allergies
- ☐ Arthritis
- ☐ Blood disorders
- ☐ Broken bones/fractures
- ☐ Cancer
- ☐ Circulation problems
- ☐ Depression
- ☐ Developmental/growth problems
- ☐ Diabetes/high blood sugar
- ☐ Head injury
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Infectious disease (ie: tuberculosis, hepatitis)"
- ☐ Kidney problems
- ☐ Low blood sugar/ hypoglycemia
- ☐ Lung problems
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Repeated infections
- ☐ Seizures/epilepsy
- ☐ Skin diseases
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Ulcers/stomach problems
- ☐ Other:_____

(If history includes cancer, please complete the following)

CANCER TREATMENT PROGRESSION
Include chemotherapy, cancer surgeries, radiation & other interventions"

Date Initiated	Date Completed	Type of Treatment

For Men: Diagonsis of prostate disease? ☐ Yes ☐ No

For Women: Diagnosis of:

Pelvic inflammatory disease	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
Trouble with menstrual cycle	☐ Yes	☐ No
Complicated pregnancies/deliveries	☐ Yes	☐ No
Pregnant, or might be pregnant"	☐ Yes	☐ No

Current Limitations (check all that apply)

- ☐ Difficulty with locomotion/movement
- ☐ Bed mobility
- ☐ Transfers (ie: moving from bed to chair, bed to toilet, etc.)"
- ☐ Difficulty with self-care (ie: bathing, dressing, toileting)
- ☐ Difficulty with home management (ie: household chores, shopping, driving/transportation)
- ☐ Difficulty sleeping
- ☐ Difficulty with community and work activities/integration
  - ☐ work/school
  - ☐ recreation/play activity
- ☐ Gait
  - ☐ on level
  - ☐ on stairs
  - ☐ on ramps
  - ☐ on uneven terrain

Past Surgery (other than for cancer) ☐ Yes ☐ No
(If yes, please describe and include dates)

	Month	Year
_____	☐☐	☐☐☐☐
_____	☐☐	☐☐☐☐
_____	☐☐	☐☐☐☐

Illnesses within the past year: (check all that apply)

- ☐ Bowel problems
- ☐ Chest pains
- ☐ Coordination problems
- ☐ Cough
- ☐ Difficulty sleeping
- ☐ Difficulty swallowing
- ☐ Difficulty walking
- ☐ Dizziness or blackouts
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hoarseness
- ☐ Joint pain or swelling
- ☐ Loss of appetite
- ☐ Loss of balance
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Pain in arms/legs
- ☐ Shortness of breath
- ☐ Urinary problems
- ☐ Vision problems
- ☐ Weakness in arms/legs
- ☐ Weight loss/gain
- ☐ Skin irritation/infection
- ☐ Other: _____