PENINSULA Physical Therapy
Sports · Orthopedics · Hands

IF YOU ALREADY HAVE A LIST WE WOULD BE HAPPY TO PHOTOCOPY IT

NAME: **BD:**

MEDICAL HISTORY

Do you have any of the following:

☐ Diabetes ☐ Stroke ☐ High Blood pressure ☐ Are you pregnant?
☐ Bloodborne disease ☐ Heart Disease ☐ Cancer (type): _____
☐Seizures ☐ Asthma ☐ Arthritis ☐ Polio
☐ Metal implants ☐ Heart Attack ☐ Pacemaker ☐ Multiple Sclerosis
☐ Numbness / tingling (where)_____ ☐ Parkinson's
☐ Dementia ☐ Joint Replacements:_____

Please list any other pertinent medical information _____
_____
_____
_____
_____

MEDICATIONS

Name	Dosage	Frequency	Administration (oral / injection …)

Signature_____ Date_____