Pouzol Physical Therapy, P.A.
33 B Penn Plaza
Bangor, Maine

Medical History

Name: ____ Date: ________________

Illness/injury requiring treatment: ____

Date of Birth: _________________________ Date of injury: _________________________

Have you had Physical Therapy **in this calendar year**	Yes ☐ No ☐ If yes, how many sessions:

Please indicate if you have had any of the following **related to your injury:**

X-ray/MRI	Yes ☐ No ☐ If yes, explain:
Surgery	Yes ☐ No ☐ If yes, explain:

Please check any of the following if applicable:

Heart Conditions	Yes ☐ No ☐	If yes, explain:
Abnormal Heartbeat/ Pacemaker	Yes ☐ No ☐	If yes, explain:
Asthma/Emphysema	Yes ☐ No ☐	If yes, explain:
Recent weight loss/ gain	Yes ☐ No ☐	If yes, explain:
Diabetes	Yes ☐ No ☐	If yes, explain:
Cancer	Yes ☐ No ☐	If yes, explain:
Joint sprains/strains	Yes ☐ No ☐	If yes, explain:
Joint pain/swelling	Yes ☐ No ☐	If yes, explain:
Joint replacements	Yes ☐ No ☐	If yes, explain:
History of falls	Yes ☐ No ☐	If yes, explain:
Shortness of breath	Yes ☐ No ☐	If yes, explain:
History of fractures	Yes ☐ No ☐	If yes, explain:

OVER →

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Leg/Arm swelling or Weakness	Yes ☐ No ☐	If yes, explain:
Numbness or tingling	Yes ☐ No ☐	If yes, explain:
Dizziness	Yes ☐ No ☐	If yes, explain:
Headaches	Yes ☐ No ☐	If yes, explain:
Ringing/Fullness in Ears	Yes ☐ No ☐	If yes, explain:
Glasses/contact Lenses	Yes ☐ No ☐	If yes, explain:
History of seizures	Yes ☐ No ☐	If yes, explain:
Recent fever, illness Or infection	Yes ☐ No ☐	If yes, explain:
Pregnant or planning to become pregnant?	Yes ☐ No ☐	If yes, explain:

Allergies: ____
____

Current Medications: Please list ALL medications and purpose.

- ____
- ____
- ____
- ____
- ____

Surgeries: Please list ALL surgeries and dates.

- ____
- ____
- ____
- ____
- ____

Primary Care Physician's Name: ____

Emergency Contact (Name & Phone Number): _______________________________________