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# MEDICAL HISTORY FORM

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Physical demands of work (i.e. prolonged sitting, standing, walking, climbing, lifting/carrying requirements, etc):  
\_\_\_\_\_  
\_\_\_\_\_

Current work status:     Full duty                       Modified duty                       Light duty                       Out of work

Recreational/sporting activities: \_\_\_\_\_

Current rec/sports status:     Full participation                       Limited participation                       Out of action

Has your physician given you any other activity restrictions?     Yes                       No

If yes, please describe: \_\_\_\_\_

Medical conditions (please check and complete as appropriate):

Heart trouble? Please specify, i.e. heart attack, congestive heart failure, faulty valve: \_\_\_\_\_

High blood pressure? If yes, is it controlled?  
 Yes                       No

Stroke? If yes, do you have any remaining difficulties?  
 Yes                       No

Pacemaker/Defibrillator?

Diabetes? If yes, is it controlled?  
 Yes                       No

How do you control your diabetes?  
 Medication                       Diet                       Both

Seizures? If yes, when was your last seizure? \_\_\_\_\_

Osteoporosis? If yes, have you had any related fractures? \_\_\_\_\_

Cancer? If yes, where? \_\_\_\_\_  
Has it been successfully treated?     Yes                       No  
Any recurrences?                       Yes                       No

Respiratory/Breathing difficulty?

Other: \_\_\_\_\_