

Medical History

Primary Care Physician's Name _____ Phone _____

1. Please list any past serious illnesses or operations:

2. Are you currently taking any medications? YES NO

Please describe: _____

3. Do you smoke? YES NO

4. Do you use alcohol? YES NO

5. Do you use other drugs? YES NO

6. Are you allergic to: latex aspirin/NSAIDs topical ointments Other _____

7. (Women only) Are you currently pregnant? YES NO

Do **YOU** or have **YOU** ever had the following:

Anemia (low blood count).... YES NO

Asthma..... YES NO

Cancer..... YES NO

Chemotherapy..... YES NO

Circulatory Problems..... YES NO

Emphysema..... YES NO

Glaucoma..... YES NO

Hepatitis-Type____..... YES NO

Herpes..... YES NO

HIV/AIDS..... YES NO

Kidney Problems..... YES NO

Low Blood Pressure..... YES NO

Osteoporosis..... YES NO

Pacemaker..... YES NO

Psychiatric Care..... YES NO

Respiratory Disease (COPD)... YES NO

Thyroid Problem..... YES NO

Other (please describe): _____

Anorexia..... YES NO

Bleeding Disorder..... YES NO

Chemical Dependency..... YES NO

Chronic Fatigue Syndrome..... YES NO

Diabetes..... YES NO

Epilepsy..... YES NO

Heart Disease..... YES NO

Hernia-Type_____ YES NO

High Blood Pressure..... YES NO

Jaundice..... YES NO

Liver Disease..... YES NO

Multiple Sclerosis..... YES NO

Osteoarthritis..... YES NO

Polio..... YES NO

Prostate Problem..... YES NO

Stroke..... YES NO

Ulcer..... YES NO

Assignment and Release

I hereby authorize payment directly to O'Brien Physical Therapy for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____