PLYMOUTH BAY
ORTHOPEDIC
SPORTS THERAPY

PLYMOUTH OFFICE
41 Resnik Road
Plymouth MA 02360
Phone: 781.934.7292

PATIENT MEDICAL HISTORY FORM

PATIENT INFORMATION

Name: _____ DOB: _____

Reason we are seeing you today? _____

MEDICAL INFORMATION

Please indicate if you have had any of the following:

Diagnosis:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Joint Pain
- ☐ Asthma
- ☐ Cancer, Type _____
- ☐ Clotting/Bleeding Problems
- ☐ Depression
- ☐ Diabetes
- ☐ DVT/Blood Clots/Phlebitis
- ☐ Emphysema
- ☐ Fractures/Broken Bones
- ☐ Gout
- ☐ Heart Disease/Attack
- ☐ Hepatitis
- ☐ High Blod Pressure
- ☐ High Cholesterol
- ☐ HIV Disease
- ☐ Kidney Disease/Urinary Issues
- ☐ Osteoporosis
- ☐ Reflux
- ☐ Stoke/CVA
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

Symptoms:

- ☐ Unplanned Weight Loss
- ☐ Fevers
- ☐ Headaches
- ☐ Dizziness/Fainting
- ☐ Chest Pain
- ☐ Swelling of Arms/Legs
- ☐ Blurred Vision
- ☐ Hearing Loss
- ☐ Problems with Anesthesia

Other: _____

MEDICATIONS

List all of your current medications and doses:

_____ _____
_____ _____
_____ _____

SURGICAL HISTORY

List past surgeries with approx. date.

_____ _____
_____ _____
_____ _____

CONSENT FOR TREATMENT

- ☐ I hereby request and consent to Plymouth Bay Orthopedic & Sports Therapy to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical/occupational therapist.
- ☐ I understand and am informed that, as in the practice of medicine, physical/occupational therapy may have some risks.
- ☐ I understand that I have the right to ask about these risks and have my questions answered about my interventions or treatment for my condition.
- ☐ I have carefully read and fully understand this informed Consent and will have the opportunity to discuss my condition with the treating physical/occupational therapist.
- ☐ I consent and authorize Plymouth Bay Orthopedic & Sports Therapy to administer treatment under the direction and supervision of the physical/occupational therapist.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Print Name of Parent/Legal Guardian Relationship to Patient