UNIVERSITY OF MONTANA
PHYSICAL THERAPY CLINIC
EXCELLENCE IN MOTION
32 CAMPUS DRIVE, SKAGGS 129 • MISSOULA MT 59812 • P 406-243-4006 • F 406-243-4303

MEDICAL HISTORY

Name: _____ Age: _____ Date _____

Please indicate if you have been diagnosed with, or experienced, any of the following conditions.

	YES	DATE OF ONSET	CURRENT STATUS
Ankle or Lower Leg Swelling			
Allergies			
Angina / Chest pains			
Arthritis			
Anemia / Bleeding Problems			
Asthma			
Bladder / Bowel Problems			
Blood Clots			
Cancer			
COPD			
Depression / Anxiety			
Diabetes			
Dizziness / Fainting			
Emphysema			
Epilepsy or Seizures			
Head Injury (TBI)			
Heart Disease / Pacemaker			
Hepatitis / Jaundice			
HIV / AIDS			
High Blood Pressure			
Mental Illness			
Kidney Disease			
Liver Disease			
Rheumatic / Scarlet Fever			
Shortness of Breath			
Stroke			
Ulcer / Stomach Problems			
Other:			
Other:			

Please list any other medical conditions you currently have, or have had in the past, which were not listed above:

_____

_____

_____

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ADDITIONAL MEDICAL HISTORY and MEDICATIONS

Have you had any surgeries in the past 5 years or other surgeries relevant to your current status? Yes _____ No _____
If you marked Yes, please indicate the type of surgery and date: _____

Have you had any illnesses within the past 8 weeks? Yes ☐ No ☐ What was it?_____
Are you currently, or planning to be, pregnant? Yes ☐ No ☐
Have you had any recent unexplained weight loss? Yes ☐ No ☐

Do you currently smoke or use tobacco? Yes ☐ No ☐ Packs/day?_____ How many years?_____
Have you in the past? Yes ☐ No ☐ Approximate stop date_____

Other information you would like us to know about your health care, concerns or medical status/history:_____
_____
_____
_____

Please provide a list of all medications, vitamins, and supplements that you are currently taking **OR** write them below.
Provide the amount you take, how often you take it and if this is oral (by mouth) or otherwise.

Medication or Supplement Name	Dosage:	Frequency: Times/day taken	Route: By mouth or injection?