AQUATIC THERAPY OF LOS ALAMITOS

4220 Katella Avenue, Los Alamitos, CA 90720 Phone: 562.342.9994 Fax: 562.342.9484

Past Medical History Form

Are you presently working? Yes / No Date of next physician's visit:// Date of injury / onset://	Patient Name:				D	ate:	//	
Check which applies to your current condition: Work-related Injury Recurrence of prior in Motor vehicle accident Injury related to lifting Injury related to falling Athletic/Recreational Injury Cause Unknown Other: Have you had a related surgery? Yes / No	Are you presently working? Yes / No				Date of next physician's	visit:		
Motor vehicle accidentInjury related to liftingInjury related to fallingAthletic/Recreational InjuryCause Unknown Other:	Date of injury / onset://				Have you ever had these symptoms before? Yes / No			
Athletic/Recreational InjuryCause Unknown Other:					Work-related Injury		Recurrence	of prior injur
Have you had a related surgery? Yes / No If female, are you pregnant? Yes / No Do you have, or have you had any of the following: (Please circle Y for Yes, or N for No) Diabetes Y N Hypoglycemia Y N Chest Pain / Angina Y N Osteoarthritis Y N High Blood Pressure Y N Osteoporosis Y N Heart Disease Y N Hernia Y N Heart Attack Y N Seizures Y N Heart Palpitations Y N Metal Implants Y N Heart Palpitations Y N Metal Implants Y N Headaches Y N Dizziness / Fainting Y N Kidney Problems Y N Surgeries Y N Kidney Problems Y N Surgeries Y N Kidney Problems Y N Skin Abnormalities Y N Stroke Y N Nausea / Vomiting Y N Bowel / Bladder Abnormalities Y N Ringing in Your Ears Y N Asthma / Breathing Difficulties Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.					Injury related to lifting Injury related to			ed to falling
Do you have, or have you had any of the following: (Please circle Y for Yes, or N for No) Diabetes Y N Hypoglycemia Y N Chest Pain / Angina Y N Osteoarthritis Y N High Blood Pressure Y N Osteoporosis Y N Heart Disease Y N Hernia Y N Heart Attack Y N Seizures Y N Heart Palpitations Y N Metal Implants Y N Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Kidney Problems Y N Surgeries Y N Stroke Y N Nausea / Vomiting Y N Bowel / Bladder Abnormalities Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above. please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	Athletic/Re	ecreati	ional	Injury _	Cause Unknown	Other	:	
Diabetes Y N Hypoglycemia Y N Chest Pain / Angina Y N Osteoarthritis Y N High Blood Pressure Y N Osteoporosis Y N Heart Disease Y N Hernia Y N Heart Attack Y N Seizures Y N Heart Palpitations Y N Metal Implants Y N Pacemaker Y N Dizziness / Fainting Y N Heart Palpitations Y N Metal Implants Y N Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Cancer Y N Surgeries Y N Stroke Y N Nausea / Vomiting Y N Bowel / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	Have you had a related surgery?	Ye	s /	No	If female, are you preç	gnant?	Yes / N	o
Chest Pain / Angina Y N Osteoarthritis Y N High Blood Pressure Y N Osteoporosis Y N Heart Disease Y N Hernia Y N Heart Attack Y N Seizures Y N Heart Palpitations Y N Metal Implants Y N Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Cancer Y N Surgeries Y N Cancer Y N Skin Abnormalities Y N Stroke Y N N Ringing in Your Ears Y N Bowel / Bladder Abnormalities Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	Do you have, or have you had ar	y of th	ne fol	lowing:	(Please circle Y for Yes, or N for No)			
Chest Pain / Angina Y N Osteoarthritis Y N High Blood Pressure Y N Osteoporosis Y N Heart Disease Y N Hernia Y N Heart Attack Y N Seizures Y N Heart Palpitations Y N Metal Implants Y N Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Cancer Y N Surgeries Y N Cancer Y N Skin Abnormalities Y N Stroke Y N N Ringing in Your Ears Y N Bowel / Bladder Abnormalities Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	Diabetes	Υ	N		Hypoglycemia		Y	N
High Blood Pressure Y N Osteoporosis Y N Heart Disease Y N Hernia Y N Heart Attack Y N Seizures Y N Heart Attack Y N Seizures Y N Heart Palpitations Y N Metal Implants Y N Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Cancer Y N Skin Abnormalities Y N Stroke Y N Nausea / Vomiting Y N Bowel / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	Chest Pain / Angina	Υ					Υ	
Heart Disease Y N Hernia Y N Heart Attack Y N Seizures Y N Heart Palpitations Y N Metal Implants Y N Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Cancer Y N Skin Abnormalities Y N Stroke Y N N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	_	Υ	Ν		Osteoporosis		Υ	N
Heart Palpitations Y N Dizziness / Fainting Y N Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Cancer Y N Skin Abnormalities Y N Stroke Y N NAusea / Vomiting Y N Bowel / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	-	Υ	Ν		·		Υ	N
Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Surgeries Y N Surgeries Y N Stroke Y N N Nausea / Vomiting Y N N Nausea / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Smoking Y N N Liver / Gallbladder Problems Y N Other: Y N Other: Y N Diff you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	Heart Attack	Υ	Ν		Seizures		Υ	N
Pacemaker Y N Dizziness / Fainting Y N Headaches Y N Fracture Y N Kidney Problems Y N Surgeries Y N Surgeries Y N Surgeries Y N Stroke Y N N Nausea / Vomiting Y N N Nausea / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Smoking Y N N Liver / Gallbladder Problems Y N Other: Y N Other: Y N Diff you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.	Heart Palpitations	Υ	Ν		Metal Implants		Υ	N
Kidney Problems Y N Surgeries Y N Cancer Y N Skin Abnormalities Y N Stroke Y N Nausea / Vomiting Y N Bowel / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	·	Υ	Ν		· ·		Υ	N
Cancer Y N Skin Abnormalities Y N Stroke Y N Nausea / Vomiting Y N N Howel / Bladder Abnormalities Y N Ringing in Your Ears Y N N Housea / Vomiting Y N N Ringing in Your Ears Y N N Housea / Rheumatoid Arthritis Y N N Smoking Y N N Smoking Y N N Smoking Y N N Smoking Y N N Other: Y N N N N N N N N N N N N N N N N N N	Headaches	Υ	Ν		Fracture		Υ	N
Stroke Y N Nausea / Vomiting Y N Bowel / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	Kidney Problems	Υ	Ν		Surgeries		Υ	N
Bowel / Bladder Abnormalities Y N Ringing in Your Ears Y N Urine Leakage Y N Rheumatoid Arthritis Y N Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	•	Υ	Ν				Υ	N
Urine Leakage Y N Rheumatoid Arthritis Y N Smoking Y N Smoking Y N Other: Y N Other: Y N Other: Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Other: Y N Diver / Gallbladder Problems Y N Diver /	Stroke	Υ	Ν		Nausea / Vomiting		Υ	N
Asthma / Breathing Difficulties Y N Smoking Y N Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	Bowel / Bladder Abnormalities	Υ	Ν		-	s	Υ	N
Liver / Gallbladder Problems Y N Other: Y N If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	Urine Leakage	Υ	Ν				Υ	N
If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	_	Υ	Ν		Smoking		Υ	N
Include any other pertinent information regarding your past medical history. Do you have any allergies? Yes / No If yes, please list your allergies:	Liver / Gallbladder Problems	Υ	N		Other:		Y	N
Do you have any allergies? Yes / No If yes, please list your allergies:								
	Include any othe	r pert	tiner	nt infor	mation regarding your pas	t med	ical history	<u>/.</u>
Are you presently taking any medication? Yes / No If yes, please list what medications and for what condition	Do you have any allergies? Yes	/ N	o I	f yes, ple	ease list your allergies:			
	Are you presently taking any med	dicatio	n? `	Yes / N	lo If yes, please list what med	ications	and for wha	t condition: