AQUATIC THERAPY OF LOS ALAMITOS
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Past Medical History Form

Patient Name: _____ Date: _____/ _____/_____

Are you presently working? Yes / No Date of next physician's visit: _____/_____/_____

Date of injury / onset: _____/_____/_____ Have you ever had these symptoms before? Yes / No

Check which applies to your current condition: _____ Work-related Injury _____ Recurrence of prior injury

_____ 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 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
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: _____

_____

Are you presently taking any medication? Yes / No If yes, please list what medications and for what condition:

_____

_____