MEDICAL HISTORY

Name:_________________________________Age:________________DOB:________________
Type of cancer:________________________Date of diagnosis:____________________________
Oncologist:_________________Radiation Oncologist:___________________________________
Location:(Left/Right Breast)____
Presenting Symptoms (symptoms that led to diagnosis: fatigue, nausea, etc.)____
Type of surgery(s):____
Date(s) of surgery:____
Breast Surgeon's name:_____________ Plastic Surgeon's name:___________________________
Post surgery treatment: (chemotherapy or radiation)_______________________________
Length of treatment:____
Date of final treatment or still in treatment?____
Complications?____
Medications for cancer or cancer complications:____
Describe your current complaints:____
____
Current level of pain (0= no pain, 10= requires emergency room care):
At rest: 1 2 3 4 5 6 7 8 9 10
Movement: 1 2 3 4 5 6 7 8 9 10
Since your condition began have your symptoms: decreased not changed increased
What makes your problem better?____
What makes your problem worse?____
What percentage of the time are your symptoms present? 0% 25% 50% 75% 100%
Please list all medications- Over the counter and prescription
____
____
____
Family Medical History:
____ Cancer Type?___________Family member ?____
____ Cancer Type?___________Family member ?____
____ Diabetes Family member(s)?____
____ High Blood Pressure Family member(s)?_______________________________________
____ Heart Attacks Family member(s)?____
____ Heart Surgery Family member(s)?____
____ Obesity Family member(s)?____
____ Stroke Family member(s)?____

Have you had physical therapy this calendar year? ___________________________________
Past PT experience: Positive or Negative
Dependable Family Support: Yes or No
Hectic Work Schedule: Yes or No Profession: ________________________________

Name:____Email Address:_______________________

Please check any of the following that are in your health history:

____Ast ___Sleeping Problems ____ Alcohol Abuse
____Shortness of Breath ___ Emotional/Psychological ____ Anemia
____Coronary Artery Disease ___ Headaches ____ Numbness/Tingling
____Neurological Problems ____Pacemaker ____ Dizziness or Fainting
____High Blood Pressure ____Blurred Vision ____Metal Implants
____Heart Attack ____Diabetes ____Incontinence
____Heart Surgery ____Weakness ____Smoking
____Stroke or TIA ____Weight Loss ____Arthritis/Swollen joints
____Blood clot or Emboli ____Night Sweats ____Are you pregnant?
____Epilepsy or Seizures ____Hernia ____Osteoporosis

Allergies: NA/please list____

Height:______________________ Weight:_______________________

Please list any past surgeries:____

____

____

Please list any past hospitilaztions:____

Please Circle any/all items that are currently challenging:

Stairs Recreational Activities Shopping Household chores Dressing
Attending Public Events Yard Work Self Care Rising from low surface
Prolonged Walking Prolonged Standing Playing with kids/grandkids

Please Circle any/all items that you or someone close to you currently experiences:

Obesity Cardiovascular Disease Cancer Tobacco use Cardiopulmonary Disease
Hearing loss Visual Deficits Physically inactive Psychological Disorders COPD Asthma
Congestive Heart Failure Depression

Feel free to elaborate below on any items circled above: ___________________________________

____

____

Please list three goals you would like to achieve while in physical therapy:

1.____
2.____
3.____

Patient/Guardian Signature:_________________________________Date:_______________________

____ __________________________
Physical Therapist Signature Date