ADVANTAGE SPORTS MEDICINE AND PHYSICAL THERAPY, INC.
245 NORTH STREET, STONEHAM, MA 02180 • PHONE (781) 438-7221 • FAX (781) 438-7208

PATIENT MEDICAL INFORMATION FORM

NAME: _____ **Date of Birth** ____/_____/_____

1) **MEDICATIONS:** Are you taking any prescription medications for this condition? Yes /No
   PLEASE PROVIDE OFFICE STAFF WITH A LIST OF ALL CURRENT MEDICATIONS/DOSAGES
2) **Medical History:**

a) Height ____feet_____inches Weight _____lbs
b) Do you smoke? Yes/No If so, how may packs/day _____
c) How often have you completed at least 20' of exercise such as brisk walking, cycling or jogging prior to onset of this condition?: NONE 1-2x/wk 3-5x/wk Daily
d) Please indicate your level of pain in the past 24 hours (Please circle number)
   NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE/BAD as it can be
e) How many days since the beginning of this condition:

___0-7 ___8-14 ____15-21 ____22-3 months ____3-6 months ____ More than 6 months

3) **Fall History:** Have you had any falls in the past year ? Yes/No
   If so, now many times? _____ Any fall with injury in the past year? _____

4) **Medical Conditions.** Please check all that apply:

- ☐ Arthritis (rheumatoid/osteoarthritis)
- ☐ Asthma
- ☐ Angina
- ☐ Heart Attack
- ☐ Peripheral Vascular Disease
- ☐ Neurological Disease (such as Multiple sclerosis or Parkinson's)
- ☐ COPD or emphysema or ARDS (acute respiratory distress)
- ☐ Visual Impairments (such as cataracts, glaucoma, macular degeneration)
- ☐ Back pain (neck or low back or degenerative disc or spinal stenosis)
- ☐ Pacemaker
- ☐ Cancer if so, specify type/when _____
- ☐ Depression
- ☐ Prior Surgery (please list below)
- ☐ Sleep dysfunction
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Diabetes Type 1 or 2 (specify)
- ☐ Congestive Heart Failure or heart disease
- ☐ High Blood Pressure
- ☐ Stroke or TIA if so when _____
- ☐ Allergies if so, specify _____
- ☐ Gastrointestinal Disease (ulcer, reflux, bowel, liver, gall bladder)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Headaches or Migraines
- ☐ Anxiety or Panic disorders/other mental illness
- ☐ Hepatitis/AIDS
- ☐ Prosthesis or implants
- ☐ Epilepsy/Seizures/Fainting/Dizziness
- ☐ Incontinence

Others not listed above _____

Surgeries (please list all) _____

I, the undersigned, do hereby agree and give consent to ADVANTAGE SPORTS MEDICINE &PHYSICAL THERAPY to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition.

_____ _____

Print Patient Name Patient Signature