FIT-N-WISE
A Wise Health System Service

Past Medical History

Patient Name: _____ Date of Birth: _____

Please circle the following conditions if you have had:

Angina	Osteoporosis	Dislocation	Heart Attack
Stroke	Whiplash	Emotional Problems	Nervous Problems
Heart Disease	Heart Surgery	Kidney Disease	Cancer- Type_____
Tumors	Gout	Diabetes	Fractures/ Broken
Neck Injuries	Jaw Injuries/TMJ	Epilepsy/Seizures	Bones-locations:
Muscle Strains	Arthritis	Lung Disease	_____
Allergies	RSV	Circulatory Problems	_____
Bronchitis	Joint Strains	High Blood Pressure	Back Injuries
Asthma	Head Injury	Low Blood Pressure	Ear Infections
Apnea	Chewing Problems	Swallowing problems	Pacemaker

Gastrointestinal Problems Alcohol/ Substance Abuse Problems

Circle if you have recently experienced the following:

Headaches	Seizures	Shortness of breath	Pain when Coughing or sneezing Hoarseness
Dizziness	Tingling, Numbness	Difficulty expressing ideas	Muscle Pain with Exertion
Falls	Sore Throat	Unusual Congestion	Difficulty with comprehension
Tremors	Balance problems	Attention problems	Concentration problems
Facial Drooping	Difficulty Sleeping	Unusual skin coloration	Blurred/Double vision
Loss of Feeling	Pocketing of Food	Changes in Bowel	Unusual Crying/ Fussiness
Unusual Fatigue	Muscle Pain at rest	Unexplained Weight Loss	

Constant pain unrelieved by rest or movement

Regularly choking on food Type_____

List any medical conditions not identified above:

_____

List current medications:

_____

_____

List any major surgeries and hospitalizations:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Are you pregnant? YES NO Do you smoke? YES NO packs per day: ___

Have any of the following diagnostic tests been performed:

XRAY MRI EMG/NCV MODIFIED BARIUM SWALLOW

If so when and results: _____

PLEASE LIST ANY PHYSICIAN/THERAPEUTIC RESTRICTIONS: _____

_____

_____ _____

PATIENT OR GUARDIAN SIGNATUR DATE

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