Cornerstone Therapy Services

Patient Medical History Form

Name:_____ DOB:_____ Date:_____

Updated Date:_____

Updated Date:_____

Past Medical History

Have you ever had any of the following: If YES, please explain (type, date)

1. Bone/Joint Condition
- Osteoporosis/Osteopenia Yes No
- Arthritis/Gout/RA Yes No
- Replacement Yes No
  - Type:_____

2. Metal Implants Yes No
- Type/Location_____

3. Neurological Condition
- Stroke/TBI Yes No
- Multiple Sclerosis Yes No
- Parkinson's Disease Yes No
- Seizures/Epilepsy Yes No
- Other_____

4. Vertigo/Dizziness Yes No

5. Migraine/Tension Headaches Yes No

6. Dementia/Alzheimer's Yes No

7. Myofascial/Fibromyalgia Pain Yes No

8. Auto-immune disease/disorder Yes No
- Type:_____

9. Cancer Yes No
- Active/Remission
- Type:_____
- Year diagnosed_____

10. Heart Condition
- High Blood Pressure Yes No
- Heart Attack Yes No
- A-fib Yes No
- Congestive heart failure Yes No
- Pacemaker Yes No
- Other_____

11. Kidney Disease Yes No
- Type:_____

12. Liver Disease Yes No
- Type:_____

13. Diabetes Yes No
- Type I or Type II

14. Digestive/Stomach Issues Yes No
- Type:_____

15. Urinary Problems Yes No
- UTI Yes No
- Incontinence Yes No
- Other:_____

16. Allergies
- Seasonal Yes No
- Latex Yes No
- Other:_____

17. Skin Conditions
- Lumps/Thickening of skin Yes No
- Sores that don't heal Yes No
- Mole changes (size, color) Yes No
- Other:_____

18. Blood Disorders Yes No
- Type:_____

19. Vascular Disease Yes No
- Type:_____

20. Respiratory Disease
- Chronic Bronchitis Yes No
- Pneumonia Yes No
- Emphysema/COPD Yes No
- Asthma Yes No
- Other:_____

21. Transplanted Organ Yes No
- Organ_____

22. Thyroid Condition Yes No
- Hyper or Hypo
- Other:_____

23. Mental Health
- Depression Yes No
- Anxiety Yes No
- Other:_____

24. Pregnant Currently/Past Yes No
- Due Date_____

25. COVID Yes No
- When_____
- Residual Effects_____

Other (please describe) _____

_____

_____

Continued on the back!

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Patient Medical History Form

Date:_____

Medications

1. Are you taking any prescription or over-the-counter medication? Yes No

   List medications or provide a copy of medications_____

   _____

   _____

   _____

Hospitalization

Have you been hospitalized in the past 30 days. Yes No If yes, what was the date from admission _____to discharge _____ and the name of the hospital_____

Medical Testing

1. Have you had any **X-rays, MRI, CT scans**, or **Sonograms** done recently? Yes No

If yes, what test was completed?_____

When was the test completed?_____

Where was the test completed?_____

What were the results?_____

_____

Recent Surgeries

Please list any operations you have had and the date(s):_____

_____

_____

_____

General Health

1. Have you had any illness within the last 30 days (ie: cold, flu, bladder infection, COVID)? Yes No

   If yes, do you have any side effects?_____

   _____

2. Have you had any unexplained weight gain or loss in the past month? Yes No