TPPT Medical History Form Date: _____

Name:_____ Date of Birth:_____

Current problem you are seeking care for:

_____

Occupation: _____

Leisure activities: _____

Mental Health: Current level of stress High___Med___Low___ Current psych therapy? Y/N

Have you EVER been diagnosed as having any of the following conditions? Circle all that apply

Cancer: (if yes, describe what kind: _____

Heart problems	Kidney disease	Allergies:_____
High blood pressure	Anemia	_____
Ankle swelling	Epilepsy	_____
Asthma	Head Injury	
Emphysema/bronchitis	Osteoporosis	Acid Reflux/belching
Alcoholism/Drug problem	Chronic Fatigue Syndrome	Sacroiliac / Tailbone pain
Thyroid problems	Fibromyalgia	Headaches
Diabetes	Latex sensitivity	Sports injuries
Multiple sclerosis	Irritable Bowel Syndrome	Low back pain
Rheumatoid arthritis	Sexually transmitted disease	Joint replacement
Other arthritic conditions	Physical or Sexual abuse	
Depression	Raynaud's disease	
Hepatitis	Pelvic Pain	
Tuberculosis	Childhood bladder problems	
Stroke	Smoking history	

Other/Describe:_____

Date and Reason for any Surgery/Hospitalization:

1._____2._____

3._____4._____

Date and description of any significant injuries for which you have been treated (including fracture, dislocations, sprains).

1. Date/description_____
2. Date/description_____
3. Date/description_____

Ob/Gyn History (females only)
Childbirth vaginal deliveries #_____ Date(s):_____
C-Section #_____ Date(s):_____
Painful periods Y/N Prolapse or organ falling out Y/N
Vaginal dryness Y/N Pelvic/genital pain Y/N
Menopause Y/N Painful vaginal penetration Y/N
Other : _____

Males only
Prostate disorders Y/N Erectile dysfunction Y/N
Painful ejaculation Y/N
Pelvic / genital pain Y/N pain location: _____
Other : _____

Medications:
Please list any **PRESCRIPTION** medication you are currently taking:

_____

Over the Counter Medications:
Aspirin Y/N Tylenol Y/N Ibuprofen Y/N Laxatives Y/N
Decongestants Y/N Antacid Y/N Antihistamines Y/N
Vitamin Supplements: Y/N if yes please list:_____
_____

How much caffeine containing beverages do you drink per day? _____
How many days per week do you drink alcohol ?_____
IF you smoke, how many packs of cigarettes per day?_____

>> Your goals for physical therapy include :

_____

_____