PAST MEDICAL HISTORY FORM

Please Check YES for all that applies:

Hypertension	____	Dizziness/Fainting	____
Diabetes	____	Seizures	____
Cardiac Problem(s)	____	Strokes	____
Pacemaker	____	Cancer	____
Asthma	____	Currently Pregnant	____

List any Orthopedic/Musculoskeletal Problems:

____

Other:

____

- **Have you received Physical or Occupational Therapy within the last year? If yes, what was the condition treated?**

- **Have you been hospitalized for any condition within the last year? If yes, what was the condition treated?**

- **Are you currently participating in a regular exercise program? If yes, what is your exercise regimen?**