MEDICAL HISTORY

Name:_____Age:_____DOB:_____
Type of cancer:_____Date of diagnosis:_____
Oncologist:_____Radiation Oncologist:_____
Specific location: (Left/Right Breast)_____
Presenting Symptoms (symptoms that led to diagnosis: fatigue, nausea, etc.)_____
_____
Type of surgery:_____
Date(s) of surgery:_____
Breast Surgeon's name:_____Plastic Surgeon's name:_____
Post surgery treatment: (chemotherapy or radiation)_____
Length of treatment:_____
Date of final treatment or still in treatment?_____
Complications?_____
Medications for cancer or cancer complications:_____
Describe your current complaints:_____
_____
Current level of pain (0= no pain, 10= requires emergency room care):

At rest:	1	2	3	4	5	6	7	8	9	10
Movement:	1	2	3	4	5	6	7	8	9	10

Since your condition began have your symptoms: decreased not changed increased
What makes your problem better?_____
What makes your problem worse?_____
What percentage of the time are your symptoms present? 0% 25% 50% 75% 100%
Please list all medications- ***Over the counter and prescription***
_____
_____
_____
Family Medical History:
____ Cancer Type?_____Family member ?_____
____ Cancer Type?_____Family member ?_____
____ Diabetes Family member(s)?_____
____ High Blood Pressure Family member(s)?_____
____ Heart Attacks Family member(s)?_____
____ Heart Surgery Family member(s)?_____
____ Obesity Family member(s)?_____
____ Stroke Family member(s)?_____
____ Other familial illnesses (list):_____

Name:_____Age:_____Email Address:_____

Please check any of the following that are in your health history:

____Asthma	____Sleeping Problems	____ Alcohol Abuse
____Shortness of Breath	____ Emotional/Psychological	____Anemia
____Coronary Artery Disease	____Headaches	____Infectious Disease
____Chest Pain	____Numbness/Tingling	____Neurological Problems
____Pacemaker	____Dizziness or Fainting	____Diabetes
____High Blood Pressure	____Blurred Vision	____Metal Implants
____Heart Attack	____Ringing in Ears	____Incontinence
____Heart Surgery	____Weakness	____Smoking
____Stroke or TIA	____Weight Loss	____Arthritis/Swollen joints
____Blood clot or Emboli	____Night Sweats	____Are you pregnant?
____Epilepsy or Seizures	____Hernia	____Osteoporosis
____Thyroid trouble of Goiter	____Varicose Veins	

Allergies: NA/please list_____

Height:_____ Weight:_____

Please list any past surgeries:_____

_____

_____

Please list any past hospitilaztions:_____

_____

_____

Please list three goals you would like to achieve while in physical therapy:

1._____

2._____

3._____

Patient/Guardian Signature:_____Date:_____

I have read and reviewed the medical history of_____

_____ _____

Physical Therapist Signature Date