MAXIMUM REHAB
PHYSICAL THERAPY CENTER

Medical History and Systems Review

Patient Name _____

Date _____

Cardiovascular System	Yes	No
elevated cholesterol	___	___
sweating associated with pain	___	___
palpitations	___	___
swelling of extremities	___	___
history of smoking	___	___
orthopnea (difficulty breathing)	___	___

G.U. System	Yes	No
dysuria (painful urination)	___	___
hematuria (blood in urine)	___	___
palpitations	___	___
incontinence	___	___
frequent urination	___	___
urinary urgency	___	___
vaginal discharge	___	___
dysmenorrhea (painful menstruation)	___	___
post-menopausal vaginal bleeding	___	___
dyspareunia (painful intercourse)	___	___
infertility	___	___
hx of STD	___	___
date of last period	___	___

Neurological System	Yes	No
ataxia (poor coordination)	___	___
memory lapses	___	___
confusion	___	___
head trauma	___	___
neurological disorder	___	___
if yes, Dx _____		
tremors	___	___
slurred speech	___	___
hearing/visual disturbances	___	___

History of Falls	Yes	No
	___	___
if yes, # of falls in past 6 months	_____	
# of falls in past 6 months	_____	

GI System	Yes	No
difficulty swallowing	___	___
heartburn	___	___
jaundice	___	___
food intolerance	___	___
constipation	___	___
diarrhea	___	___
change in stool	___	___
rectal bleeding	___	___
gall bladder problems	___	___
liver problems	___	___

Pulmonary System	Yes	No
dyspnea	___	___
wheezing	___	___
prolonged cough	___	___
sputum production	___	___
if yes, amount/color	_____	

Endocrine System	Yes	No
excessive thirst	___	___
excessive hunger	___	___
polyuria	___	___
excessive sweating	___	___
fatigue	___	___
weakness	___	___
thyroid problem	___	___
if yes, Dx _____		

Other Systems	Yes	No
ear,nose,throat	___	___
skin conditions	___	___
lymphatic	___	___
psychiatric	___	___
musculoskeletal	___	___