MEDICAL HISTORY

Please complete the following checklist. If you are presently troubled by the condition, please check the **PRESENT** column. If you have experienced the condition in the **PAST** but are not currently experiencing the condition, please check the **PAST** column.

	PRESENT	PAST
High Blood Pressure	________	_____
Angina	________	_____
Heart Attack	________	_____
Stroke	________	_____
Asthma	________	_____
HIV / AIDS	________	_____
Systemic Lupus	________	_____

	PRESENT	PAST
Hepatitis	________	_____
Epilepsy	________	_____
Diabetes	________	_____
Rheumatoid Arthritis	________	_____
Pregnancy	________	_____
Cancer	________	_____
Tumors	________	_____

Other____________________________________

Other______________________________

Please list ALL the medications / vitamins with dosages

Medication	**Dosage**	**Medication**	**Dosage**

Please list ALL surgical procedures / surgery dates

Surgery	**Dates**

ACKNOWLEDGEMENT OF THE HIPAA PRIVACY RULE

The Privacy Rule standards address the use of disclosure of the individuals' health information - called "protected health information" - by organizations subject to Privacy Rule called "covered entities" as well as standards for individuals' rights to understand and control how their health information is used. The Rule strikes a balance that permits important use of information while protecting the privacy of people who seek care. **Please be advised that Bell Plaza Physical Therapy will not release any of your medical records unless otherwise authorized by you or requested by a public health authority that is legally authorized to receive such reports for the purpose of preventing or controlling disease, injury or disability.**

Patient Name(please print) ______________________________________

Patient signature:____ Date:__________________