United Therapeutics Corp.
Institute for Physical Rehabilitation

Patient Name: _____
Date: _____

HISTORY

Age:_____ Height:_____ Weight:_____
Race: ☐ Asian ☐ Pacific Islander/Polynesian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American Indian ☐ Other
Sex: ☐ Male ☐ Female
Allergies: ☐ No ☐ Yes - If *yes,* please list: _____
Date of onset/injury for *this* episode: _____
Highest educational level: ☐ did not complete HS ☐ completed HS ☐ college, no degree ☐ college undergrad degree ☐ post-grad
Your current overall health status is: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Past Medical Hx:

Please check (☑) *any* and *all* of the following conditions which ***YOU*** have ever had:

- Allergies - seasonal ☐ No ☐ Yes
- Allergies - foods/meds ☐ No ☐ Yes
- Arthritis ☐ No ☐ Yes
  - Rheumatoid Arthritis ☐ No ☐ Yes
  - Osteoarthritis ☐ No ☐ Yes
- Asthma ☐ No ☐ Yes
- Back Pain ☐ No ☐ Yes
- Balance problems/dizziness ☐ No ☐ Yes
- Breast Cancer ☐ No ☐ Yes
- Broken Bones ☐ No ☐ Yes
- Carpal Tunnel ☐ No ☐ Yes
- Colon Cancer ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes
- Eczema (rashes) ☐ No ☐ Yes
- Emphysema ☐ No ☐ Yes
- Headaches ☐ No ☐ Yes
- Heart Problems ☐ No ☐ Yes
- High Blood Pressure ☐ No ☐ Yes
- Mental Illness ☐ No ☐ Yes
- Migraine Headaches ☐ No ☐ Yes
- Osteoporosis ☐ No ☐ Yes
- Seizures ☐ No ☐ Yes
- Stomach Cancer ☐ No ☐ Yes
- Strokes ☐ No ☐ Yes
- Ulcers ☐ No ☐ Yes

Past Surgical Hx:

Please check (☑) *any* and *all* of the following ***SURGICAL procedures*** you have ever undergone:

FOR THERAPIST USE ONLY:

- Ankle ☐ No ☐ Yes → _____
- Appendectomy ☐ No ☐ Yes → _____
- Back ☐ No ☐ Yes → _____
- Brain ☐ No ☐ Yes → _____
- Elbow ☐ No ☐ Yes → _____
- Foot ☐ No ☐ Yes → _____
- Gallbladder ☐ No ☐ Yes → _____
- Hand ☐ No ☐ Yes → _____
- Heart Bypass ☐ No ☐ Yes → _____
- Hip ☐ No ☐ Yes → _____
- Hysterectomy ☐ No ☐ Yes → _____
- Knee ☐ No ☐ Yes → _____
- Neck ☐ No ☐ Yes → _____
- Shoulder ☐ No ☐ Yes → _____
- TMJ ☐ No ☐ Yes → _____
- Tonsillectomy ☐ No ☐ Yes → _____
- Wrist/Carpal Tunnel ☐ No ☐ Yes → _____
- **Other** _____ _____

Therapist Signature:

United Therapeutics Corp.
Institute for Physical Rehabilitation

Patient Name: _____
Date: _____

HISTORY

Family Hx:

Please check (☑) *any* and *all* of the following conditions which **anyone** in your ***blood-related*** family ***including your parents, grandparents, aunts/uncles, brothers or sisters etc.*** has or has ever had:

- Allergies ☐ No ☐ Yes
- Arthritis ☐ No ☐ Yes
- Asthma ☐ No ☐ Yes
- Back Pain ☐ No ☐ Yes
- Breast Cancer ☐ No ☐ Yes
- Colon Cancer ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes
- Emphyzema ☐ No ☐ Yes
- Headaches ☐ No ☐ Yes
- Heart Problems ☐ No ☐ Yes
- High Blood Pressure ☐ No ☐ Yes
- Mental Illness ☐ No ☐ Yes
- Migraine Headaches ☐ No ☐ Yes
- Osteoporosis ☐ No ☐ Yes
- Seizures ☐ No ☐ Yes
- Stomach Cancer ☐ No ☐ Yes
- Strokes ☐ No ☐ Yes
- Other _____

Social Hx:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children: ☐ No ☐ Yes ***If yes:*** how many _____; their ages _____

Work: Disabled: ☐ No ☐ Yes ***If yes:*** date disabled _____ % of disability _____

Employed: ☐ No ☐ Yes Occupation: _____ Retired: ☐ No ☐ Yes

If employed: Full time ☐ Part time ☐

Number of hours per week: _____

Student: ☐ No ☐ Yes

If student: Full time ☐ Part time ☐

Number of hours per week: _____

Habits:

Smoker: ☐ No ☐ Yes	***If yes:*** How much? _____packs/day	How long? _____ yrs
Chew Tobacco: ☐ No ☐ Yes	***If yes:*** How much? _____times per day	How long? _____ yrs
Drink Alcohol: ☐ No ☐ Yes	***If yes:*** How much? _____	How long? _____ yrs
Exercise: ☐ No ☐ Yes	***If yes:*** Weight lifting: ☐ No ☐ Yes How often? _____	Aerobic: ☐ No ☐ Yes How often? _____

Medications: Please list *all* of the **prescription** medications which you currently take:

_____

_____

_____

Please check (☑) *all* of the following over-the-counter medications which you take:

- Advil/Aleve ☐
- Antacids/Tums ☐
- Antihistamines ☐
- Aspirin ☐
- Decongestants ☐
- Ibuprofen/Naproxyn ☐
- Motrin ☐
- Tylenol ☐
- Herbal Supplements ☐
- Other ☐

Patient Signature:

Therapist Signature: