STEAMBOAT PHYSICAL THERAPY

MEDICATIONS AND SURGERIES

We are required to have this on file. Thank you!
If you have this information available on another form,
please feel free to provide a copy of that instead!

Patient Name: _____ Date of Birth:_____ Today's Date:_____

MEDICATION NAME Including prescriptions, vitamins, herbals, and over-the counter	**DOSAGE**	**FREQUENCY** e.g. daily, twice daily, as needed, etc.	**METHOD OF ADMINISTRATION** e.g. orally, injection, etc.

NAME OF SURGERY e.g. Total Knee Replacement, Rotator Cuff Repair, Triple Bypass	**DATE** Exact date (if known), Or approximate year	**SUCCESSFULLY REHABILITATED?** Did you return to the level of function you had prior to the surgery?