PATIENT MEDICAL HISTORY

NAME:_____ DATE OF BIRTH:_____

CHIEF COMPLAINT:_____

DATE OF INJURY/ONSET OF SYMPTOMS:_____ DATE OF 1ST DR. VISIT FOR THIS INJURY:_____

WHAT ARE YOUR REHABILITATION GOALS/EXPECTATIONS?_____

_____

OCCUPATION:_____ WORK STATUS:_____

LAST DATE WORKED DUE TO INJURY:_____ DATE RETURNED TO WORK:_____

HAVE YOU HAD SURGERY FOR THIS INJURY?_____ TYPE OF SURGERY:_____

APPROXIMATE DATE(S) OF SURGERY:_____

HAVE YOU HAD **ANY** OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES FOR THIS INJURY?

X-RAY	Y	N	MYELOGRAM	Y	N	FAMILY DOCTOR	Y	N
MRI	Y	N	PHYSICAL THERAPY	Y	N	ORTHOPEDIST	Y	N
CT SCAN	Y	N	OCCUPATIONAL THERAPY	Y	N	NEUROLOGIST	Y	N
EMG/NERVE CONDUCTION	Y	N	MASSAGE THERAPY	Y	N	ER CARE	Y	N

PLEASE LIST *ALL* CURRENT MEDICATIONS:_____

_____

PLEASE LIST *ALL* SURGERIES:_____

_____

PLEASE LIST *ALL* PAST AND CURRENT MEDICAL CONDITIONS:_____

_____

PLEASE CIRCLE Y OR N IF YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING PROBLEMS:

GOOD GENERAL HEALTH	Y	N	DIZZINESS	Y	N
RECENT WEIGHT CHANGES	Y	N	WEAKNESS	Y	N
FATIGUE	Y	N	STROKE/TIA	Y	N
NIGHT SWEATS/FEVERS	Y	N	**HEMATOLOGIC/LYMPHATIC**		
CARDIOVASCULAR			BRUISE EASILY	Y	N
HIGH BLOOD PRESSURE	Y	N	SLOW TO HEAL	Y	N
ANGINA/CHEST PAIN	Y	N	ENLARGED GLANDS	Y	N
CORONARY ARTERY DISEASE	Y	N	**EYES**		
HEART SURGERY/PACEMAKER	Y	N	WEAR GLASSES/CONTACTS	Y	N
MUSCULOSKELETAL	Y	N	BLURRED/DOUBLE VISION	Y	N
MUSCLE PAINS/CRAMPS	Y	N	EYE DISEASE/INJURY	Y	N
STIFFNESS/SWELLING OF JOINTS	Y	N	GLAUCOMA	Y	N
JOINT PAIN	Y	N	**GASTROINTESTINAL**		
OSTEOPOROSIS	Y	N	NAUSEA/VOMITING	Y	N
ENDOCRINE			ABDOMINAL PAIN	Y	N
EXCESSIVE THIRST/URINATION	Y	N	RECTAL BLEEDING	Y	N
THYROID DISEASE	Y	N	BLOOD IN URINE	Y	N
HORMONE PROBLEMS	Y	N	KIDNEY STONES	Y	N
EARS/NOSE/THROAT/MOUTH			**OTHER**		
HEARING LOSS/RINGING IN EAR	Y	N	CHANGES IN HAIR/NAILS	Y	N
SINUS PROBLEMS	Y	N	RASHES/ITCHING	Y	N
NOSE BLEEDS	Y	N	BREAST LUMP	Y	N
SORE THROAT	Y	N	BREAST PAIN/DISCHARGE	Y	N
VOICE CHANGES	Y	N	CHANGES IN MENSTRUAL CYCLE	Y	N
RESPIRATORY			TUBERCULOSIS	Y	N
SHORTNESS OF BREATH	Y	N	CANCER	Y	N
EXCESSIVE COUGHING	Y	N	CHEMOTHERAPY/RADIATION	Y	N
ASTHMA	Y	N	HIV/AIDS	Y	N
BRONCHITIS	Y	N	DIABETES	Y	N
EMPHYSEMA	Y	N	BLOOD CLOTS	Y	N
ALLERGIES			DEPRESSION	Y	N
FOOD	Y	N	INSOMNIA	Y	N
MEDICINE	Y	N	CONFUSION	Y	N
NEUROLOGICAL			MEMORY LOSS	Y	N
FREQUENT HEADACHES	Y	N	DO YOU SMOKE?	Y	N
SEIZURES/EPILEPSY	Y	N	ARE YOU PREGNANT?	Y	N
NUMBNESS/TINGLING	Y	N			

PATIENT SIGNATURE:_____ THERAPIST SIGNATURE:_____

DATE_____ DATE_____