

## PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Your chief complaint: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ If not an injury, date of onset of symptoms: \_\_\_\_\_

Date of 1<sup>st</sup> doctor visit for this injury: \_\_\_\_\_ Are you aware of what your diagnosis is?  Yes  No

What are your rehabilitation expectations or goals? \_\_\_\_\_

Occupation: \_\_\_\_\_ or  Retired  Student

Work Status:  Full-time  Part-time  Self-employed  Unemployed  Off Work

Last Date Worked Due to this Injury: \_\_\_\_\_ Date Returned to Work after this Injury: \_\_\_\_\_

Have you had Surgery for this injury?  Yes  No Type of Surgery: \_\_\_\_\_

Approximate date(s) of surgery: \_\_\_\_\_

Please list any Medications (prescription and non prescription) you are currently taking: \_\_\_\_\_

**Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode circle?**

X Ray	Y	N	Myelogram	Y	N	General Practitioner	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	Emergency Room Care	Y	N

**Please circle yes or no if you have, or have had any of the following problems:**

Good general health	Y	N	Shortness of breath	Y	N	Nausea/Vomiting	Y	N
Recent weight changes	Y	N	Excessive coughing	Y	N	Abdominal pain	Y	N
Fatigue	Y	N	Asthma	Y	N	Rectal bleeding	Y	N
Night sweats/fevers	Y	N	Bronchitis	Y	N	Blood in urine	Y	N
Hypertension/High blood pressure	Y	N	Frequent headaches	Y	N	Changes in hair or nails	Y	N
Angina/chest pain	Y	N	Seizures	Y	N	Rashes or itching	Y	N
Coronary artery disease	Y	N	Numbness/tingling	Y	N	Breast lump	Y	N
Heart surgery/Pacemaker	Y	N	Dizziness	Y	N	Breast pain or discharge	Y	N
Muscle pains or cramps	Y	N	Weakness	Y	N	Changes in menstrual cycle	Y	N
Stiffness/swelling in joints	Y	N	Stroke/ TIA	Y	N	Tuberculosis	Y	N
Joint pain	Y	N	Bruise easily	Y	N	Cancer	Y	N
Osteoporosis	Y	N	Slow to heal	Y	N	Chemotherapy or radiation	Y	N
Excessive thirst/urination	Y	N	Enlarged Glands	Y	N	HIV/AIDS	Y	N
Thyroid disease	Y	N	Wear glasses/contacts	Y	N	Diabetes	Y	N
Hormone problem (s)	Y	N	Blurred/double vision	Y	N	Blood clots	Y	N
Hearing loss/ringing in ears	Y	N	Eye disease or injury	Y	N	Depression	Y	N
Sinus problems	Y	N	Glaucoma	Y	N	Insomnia	Y	N
Nose bleeds	Y	N	Food	Y	N	Confusion or memory loss	Y	N
Sore throat	Y	N	Medicine	Y	N	Do you smoke	Y	N
Voice changes	Y	N	Use tobacco products	Y	N	Are you pregnant	Y	N

**Patient Signature:** \_\_\_\_\_ **Therapist Signature:** \_\_\_\_\_