

HAMILTON PHYSICAL THERAPY & SPORTS REHABILITATION CENTER, PC

PATIENT MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date: _____

Circle Yes or No

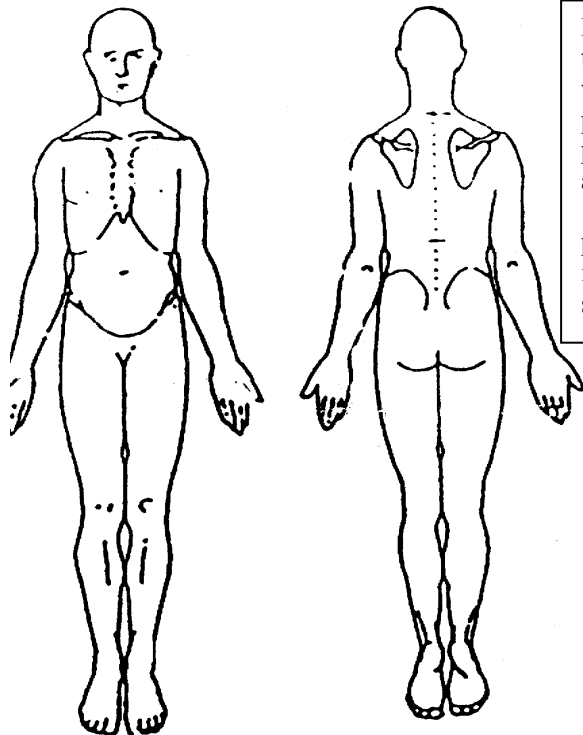
Have you or any immediate family member ever been told you have . . .

	SELF	FAMILY
Cancer?	Yes No	Yes No
Diabetes?	Yes No	Yes No
High blood pressure?	Yes No	Yes No
Heart disease?	Yes No	Yes No
Angina/Chest pain?	Yes No	Yes No
Stroke?	Yes No	Yes No
Osteoporosis?	Yes No	Yes No
Osteoarthritis?	Yes No	Yes No
Rheumatoid arthritis?	Yes No	Yes No
Bleeding disorders?	Yes No	Yes No

In the past 3 months have you had or do experience:

A change in your health?	Yes No
Nausea/Vomiting?	Yes No
Fever/Chills/Sweats?	Yes No
Unexplained weight change?	Yes No
Numbness or tingling?	Yes No
Changes in appetite?	Yes No
Difficulty swallowing?	Yes No
Changes in bowel/bladder function?	Yes No
Shortness of breath?	Yes No
Dizziness?	Yes No
Upper respiratory infection?	Yes No
Urinary tract infection?	Yes No

Please rate your pain over the last 24 hours
Circle your answer...0 1 2 3 4 5 6 7 8 9 10



Please mark on the body chart where you have pain. If you have pain in multiple areas please put a 1 by your worst pain and 2 by less intense pain and so on.

Do you have any allergies to medications?

Yes.....No
List _____

List previous surgeries and dates. _____

List medications you are currently using: _____

Do you have a history of:

- Allergies/asthma? Yes No
- Headaches? Yes No
- Bronchitis? Yes No
- Kidney disease? Yes No
- Rheumatic fever? Yes No
- Ulcers? Yes No
- Sexually transmitted disease? Yes No
- Seizures? Yes No
- Do you have a pacemaker? Yes No
- Do you have any metal in your body? Yes No
- Where? _____

Are you currently:

- Pregnant? Yes No
- Depressed? Yes No
- Under Stress? Yes No

Are your symptoms: (check one)

- Getting worse The same: how long? _____
- Improving

How are you able to sleep at night? (check one)

- Fine Moderate difficulty
- Only w/ Medication

Check all that apply.....

Do you have a problem with...?

- Hearing Vision
- Speech Communication

Have you consulted an attorney for your current Problem? Yes No

Preferred learning method....

- Verbal Written Demonstration

Do you, or have you in the past smoked tobacco?

Yes No

If yes, _____ packs X _____ years
Last tobacco use _____

Do you drink alcoholic beverages?... Yes No

If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____