**Past Medical History Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | | **PHYSICIAN INFORMATION** | | | | | | |
| Patient Name: | | | | | | | | | | | | Primary Physician: | | | | | | |
| Date of Birth: | | Marital Status: | | | | | | | | | | Referring Physician: | | | | | | |
| **CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | |
| Phone: | Occupation: | | | | | | | | | | Emergency Contact/Phone: | | | | | | | |
| Address: | | | | | | | City/State: | | | | | | | | | Zip: | | |
| **CURRENT INJURY:** | | | | | | | | | | | | | | | | | | |
| Chief Complaint: | | | | | | | | | | | | | | | | | | |
| Onset: ⎕Sudden ⎕Gradual | | Injury: ⎕ No Injury ⎕ Auto ⎕Work ⎕Other | | | | | | | | | | | | | | | | |
| If injured, briefly describe how injury occurred: | | | | | | | | | | | | | | | | | | |
| Any loss of sensation with current problem? ⎕ Yes ⎕ No | | | | | | | | Can you get comfortable at night? ⎕ Yes ⎕No | | | | | | | | | Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Have you had a similar problem before? ⎕Yes ⎕No | | | | | | If yes, how long ago? | | | | | | | | | | | | |
| Have you ever had physical or occupational therapy for this similar problem? ⎕Yes ⎕ No | | | | | | | | | | | | | | | If yes, what type of treatment did you receive? | | | |
|  | | | | | | | | | | | | | | | | | | |
| Do you have pain related to your current problem? ⎕ Yes ⎕ No | | | | | | | | | | Where is the pain? (Mark diagram below using the “key”) | | | | | | | | |
| What activities/positions decrease your pain? | | | | | | | | | | | | | | pain-drawing 6inch  **KEY**  **|| Numbness**  **00 Pain**  **XX Tingling** | | | | |
| What activities does pain interfere with or prevent you from doing? | | | | | | | | | | | | | |
| Has the pain spread? ⎕ Yes ⎕ No | | | If yes, where? | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Describe your pain/symptoms: (check if applicable)  ⎕ Stays all the time ⎕Throbbing ⎕Dull ⎕Burning ⎕ Comes and goes ⎕ Shooting ⎕ Numbness ⎕ Sharp ⎕ Tingling ⎕ Pricking ⎕ Pressure ⎕ Aching ⎕ Heavy  ⎕ Gnawing | | | | | | | | | | | | | |
| What activities/positions increase your pain? | | | | | | | | | | | | | |
| Please rate your pain/comfort level using scale to the right: | | | | | C:\Users\Jason\AppData\Local\Microsoft\Windows\INetCache\Content.Word\wong_baker.gif | | | | | | | | | | | | What is your goal for pain relief using the same scale? | |
| Have you sought medical help for current problem? ⎕ Doctor ⎕Chiropractor ⎕ Physical Therapy ⎕ Occupational Therapy | | | | | | | | | | | | | | | | | | |
| Have you had any x-rays/MRIs to diagnose above problem? ⎕ Yes ⎕ No If yes, when and results? | | | | | | | | | | | | | | | | | | |
| List any surgeries: | | | | | | | | | | | | | List any allergies: | | | | | |
| **DO YOU HAVE ANY OF THE FOLLOWING?** | | | | | | | | | | | | | | | | | | |
| Asthma, Bronchitis, or Emphysema | | | | | | | | | ⎕ YES ⎕ NO | | | | Poor Circulation | | | | | ⎕ YES ⎕ NO |
| Shortness of Breath/Chest Pain | | | | | | | | | ⎕ YES ⎕ NO | | | | Irregular Heartbeat | | | | | ⎕ YES ⎕ NO |
| Coronary Heart Disease | | | | | | | | | ⎕ YES ⎕ NO | | | | Low Blood Pressure | | | | | ⎕ YES ⎕ NO |
| Pacemaker | | | | | | | | | ⎕ YES ⎕ NO | | | | Rapid Heartbeat | | | | | ⎕ YES ⎕ NO |
| High Blood Pressure | | | | | | | | | ⎕ YES ⎕ NO | | | | Swelling of ankles | | | | | ⎕ YES ⎕ NO |
| Heart Attack/Surgery | | | | | | | | | ⎕ YES ⎕ NO | | | | Nausea/Stomach Pain | | | | | ⎕ YES ⎕ NO |
| Stroke/TIA | | | | | | | | | ⎕ YES ⎕ NO | | | | Vomiting | | | | | ⎕ YES ⎕ NO |
| Blood Clot/Emboli | | | | | | | | | ⎕ YES ⎕ NO | | | | Depression | | | | | ⎕ YES ⎕ NO |
| Epilepsy/Seizures | | | | | | | | | ⎕ YES ⎕ NO | | | | Forgetfulness | | | | | ⎕ YES ⎕ NO |
| Thyroid Trouble/Goiter | | | | | | | | | ⎕ YES ⎕ NO | | | | Excessive Thirst/Hunger | | | | | ⎕ YES ⎕ NO |
| Anemia | | | | | | | | | ⎕ YES ⎕ NO | | | | Fever | | | | | ⎕ YES ⎕ NO |
| Infectious Disease | | | | | | | | | ⎕ YES ⎕ NO | | | | Appetite Poor | | | | | ⎕ YES ⎕ NO |
| Diabetes | | | | | | | | | ⎕ YES ⎕ NO | | | | Weight Gain/Loss | | | | | ⎕ YES ⎕ NO |
| Cancer or Chemo/Radiation | | | | | | | | | ⎕ YES ⎕ NO | | | | Nervousness | | | | | ⎕ YES ⎕ NO |
| Arthritis/Swollen Joints | | | | | | | | | ⎕ YES ⎕ NO | | | | Chills/Sweats | | | | | ⎕ YES ⎕ NO |
| Osteoporosis | | | | | | | | | ⎕ YES ⎕ NO | | | | Pain/Weakness/Numbness in: | | | | | |
| Varicose Veins | | | | | | | | | ⎕ YES ⎕ NO | | | | Back | | | | | ⎕ YES ⎕ NO |
| Gout | | | | | | | | | ⎕ YES ⎕ NO | | | | Feet | | | | | ⎕ YES ⎕ NO |
| Loss of Sleep | | | | | | | | | ⎕ YES ⎕ NO | | | | Hands | | | | | ⎕ YES ⎕ NO |
| Emotional/Psychological Problems | | | | | | | | | ⎕ YES ⎕ NO | | | | Hips | | | | | ⎕ YES ⎕ NO |
| Bowel or Bladder Problems | | | | | | | | | ⎕ YES ⎕ NO | | | | Legs | | | | | ⎕ YES ⎕ NO |
| Severe/Frequent Headaches | | | | | | | | | ⎕ YES ⎕ NO | | | | Neck | | | | | ⎕ YES ⎕ NO |
| Vision/Hearing Difficulties | | | | | | | | | ⎕ YES ⎕ NO | | | | Shoulders | | | | | ⎕ YES ⎕ NO |
| Dizziness or Faintness | | | | | | | | | ⎕ YES ⎕ NO | | | | Arms | | | | | ⎕ YES ⎕ NO |
| Are you pregnant? | | | | | | | | | ⎕ YES ⎕ NO | | | | Sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Exercise | | | | ⎕ Daily ⎕ Weekly | | | | | | | | | Recreational Activites? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Smoking | | | | ⎕ Daily ⎕ Weekly | | | | | | | | | Other Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Alcohol Consumption | | | | ⎕ Daily ⎕ Weekly | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| LIST ANY AND ALL MEDICATIONS, NAME/DOSE/FREQUENCY: (Please include Prescription, Over-the-Counter, Herbal, and Vitamin/Mineral/Dietary Supplements)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| Are you aware of your Diagnosis? | | | | | | | | ⎕ YES ⎕ NO | | | | | Are you aware of your Prognosis? | | | | | ⎕ YES ⎕ NO |

**Patient/Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_