Patient Medical History v3.0

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Today's date:

PAST MEDICAL HISTORY

Please check any condition you have been medically diagnosed to have:

❑ High blood pressure	❑ Circulation disorders	❑ Falls or Loss of Balance
❑ Low blood pressure	❑ Breathing Disorders (specify)_____	❑ Diabetes
❑ Heart Condition	❑ Allergies Food	❑ Cancer (specify)_____
❑ Pacemaker	❑ Allergies Medication	❑ Unexplained Weight Loss
❑ High Cholesterol	❑ Allergies Environment	❑ Thyroid Problems
❑ Stroke	❑ Allergies Latex or Adhesives	❑ Depression
❑ Seizures	❑ Tuberculosis (treatment or exposure)	❑ Dizziness
❑ Neurological Condition	❑ Drug/Alcohol Addiction	❑ Other (specify)_____
❑ Aids/HIV	❑ Hepatitis	❑ Are you or could you be pregnant?

List **ALL** Your **Medications** here:

List Your **Surgeries** here:

Have you received home health? ❑ Yes ❑ No

Have you been hospitalized in the last 12 months? ❑ Yes ❑ No

Have you missed work because of this injury? ❑ Yes ❑ No

When did your problem begin?

Have you had therapy before? ❑ Yes ❑ No

When?

What activities did you participate in **prior** to injury?

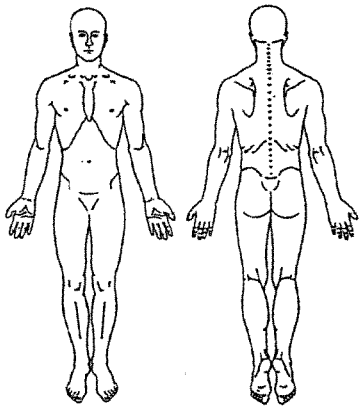
What is your therapy goal?

I would like to be contacted in the future about clinic educational and promotional events:

❑ NO ❑ YES, provide us with your email address _____

Mark the areas on the diagram where you experience symptoms:

Pain = X
Numbness = O
Stabbing or Sharp = S
Pins and Needles = N



Please rate your pain between 0-10 (Circle number below)

0 = no pain, 3 = mild pain,
5 = moderate pain, 7 = pain that would bring you tears,
10 = pain that would require you to visit the emergency room)

0—1—2—3—4—5—6—7—8—9—10

Franciscan
ST. JAMES HEALTH

OUTPATIENT REHABILITATION SERVICES
PATIENT MEDICAL HISTORY

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX

1HP