

CONFIDENTIAL MEDICAL HISTORY RECORD

Physical Medicine & Rehabilitation

Full name: _____ Date: _____

Birthdate: _____ Height: _____ Weight: _____ Male Female

I. Why are you here? Please describe your pain / symptoms:

II. History of Present Illness

A. Start of Pain or Symptoms

1. Date: _____

2. Did something cause your current condition? Yes No Unsure

If yes, what was the cause? _____

3. Does anything make your symptoms worse? If so, what makes them worse? _____

4. Is this work-related? Yes No Date of Injury: _____

B. Location of Pain

1. Where is the majority of your pain? _____

2. Do you have any numbness or tingling with the pain? _____

3. Does the pain move or travel? Please describe. _____

C. Previous Treatments – Please check all that apply.

Pain Management Physical Therapy Chiropractor

Muscle stimulator Surgery Medications

Injections Neck/back brace Other

1. When and where did you have the above? Did the treatment help or make your condition worse? Explain: _____

III. Past Medical History - Please check all that apply:

Diabetes

Seizures

High blood pressure

High cholesterol

Hepatitis

Heart disease

Arthritis

Thyroid Disease

Cancer _____

Migraines

Mental Disorder

Blood clotting problems

Tuberculosis

HIV or Aids

Kidney disease

Other: _____

Patient Name: _____

Medical Record Number: _____

Surgical History

Please list any surgeries you have had, listing brain or spine surgeries first.

Procedure	Date	Name of hospital or surgeon

Current Medications

Medication	Dose	How Often?	Reason for Taking

Medication / Other Allergies

Medication	Reaction

Please use additional space if necessary

Patient Name: _____

MR#: _____

IV. Family History

Condition	Who?	Condition	Who?
Heart Disease		Stroke	
Bleeding Problems		Cancer	
High Blood Pressure		Migraines	
Mental Disorder		Diabetes	
Other: _____			

V. Social History

A. Family Situation – please check applicable

- Married Single Widowed
 Separated Divorced Do you live alone? Yes No

B. Occupation

1. Are you currently employed? If so, what is your occupation?

2. If retired, or not working, what was your occupation?

C. Alcohol Use

1. Do you drink alcoholic beverages? Yes No
2. If yes, what is your daily, weekly, monthly or yearly use?

D. Litigation

1. Do you have any litigation (lawsuit / lawyer) regarding your condition? Yes No
2. If yes, please describe: _____

E. Substance / Drug Use

1. Do you use any illegal drugs? (marijuana, ecstasy, cocaine, etc.) Yes No
2. If yes, please describe: _____

F. Tobacco Use

1. Do you use tobacco? Yes No
2. If yes, what type? Cigarettes Chewing Tobacco Cigars Other
How often? How much? _____
3. If you were a tobacco user in the past, what year did you quit? _____

Patient Name: _____

MR#: _____

VI. Review of Systems

Do you now have, or have you had in the past, any of the following?

A. General

Symptom	No	Yes – Please explain
Fever / chills / sweats		
Feeling chronically fatigued (always tired)		
Generalized weakness (all over)		
Unintended weight loss (without trying)		
Difficulty sleeping		

B. Eyes

Blurred vision		
Double vision		
Irritation		
Vision loss		

C. Ears, nose and throat

Earache		
Ringing in ears		
Decreased hearing		
Nasal congestion		
Nosebleeds		
Sore throat		

D. Cardiovascular

Chest pain or pressure		
Heart palpitations		
Fainting		
Shortness of breath with activity		

E. Respiratory System

Cough		
Shortness of breath while at rest		
Excessive mucus		
Coughing up blood		
Wheezing		
Pain with deep breathing		

Patient Name: _____

MR#: _____

F. Digestive

Symptom	No	Yes – Please explain
Nausea / vomiting		
Change in bowel habits		
Abdominal pain		
Indigestion / heartburn		
Difficulty swallowing		

G. Genitourinary

Problems with bladder control		
Painful or difficulty urinating		
Blood in urine		
Increase in urinary frequency (more often)		
Abnormal menstrual periods		

H. Musculoskeletal

Back pain		
Joint pain		
Joint swelling		
Muscle cramps		

I. Skin

Repeat or Ongoing Rashes		
Repeat infections		

J. Neurology

Loss of feeling or use of muscle(s)		
Repeat tingling sensations / feelings		
Seizures		
Tremors		
Dizziness		
Short periods of vision loss		
Frequent falls		
Frequent headaches		
Difficulty walking		

Patient Name: _____

MR#: _____

K. Emotional / Mental

Symptom	No	Yes – Please explain
Depression		
Anxiety		
Memory loss		
Claustrophobia (fear of small or crowded places)		
Confusion		

L. Endocrine

Unable to tolerate the heat or cold		
Excessive thirst		
Excessive hunger		
Continued increase in urine output		
Unusual weight change		

M. Heme-Lymph

Abnormal bruising		
Bleeding		

N. Female Reproductive

1. Are you pregnant? Yes No
2. Are you trying to become pregnant? Yes No

O. Pharmacy Information

1. Pharmacy Name: _____
Pharmacy Phone Number: _____
Pharmacy Address: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THESE FORMS. Though time consuming, they will be extremely helpful in providing the best treatment possible.

Patient's Name (Please Print)

Patient's Signature

Date