

# HAMILTON PHYSICAL THERAPY & SPORTS REHABILITATION CENTER, PC

PATIENT MEDICAL HISTORY FORM

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

### Circle Yes or No

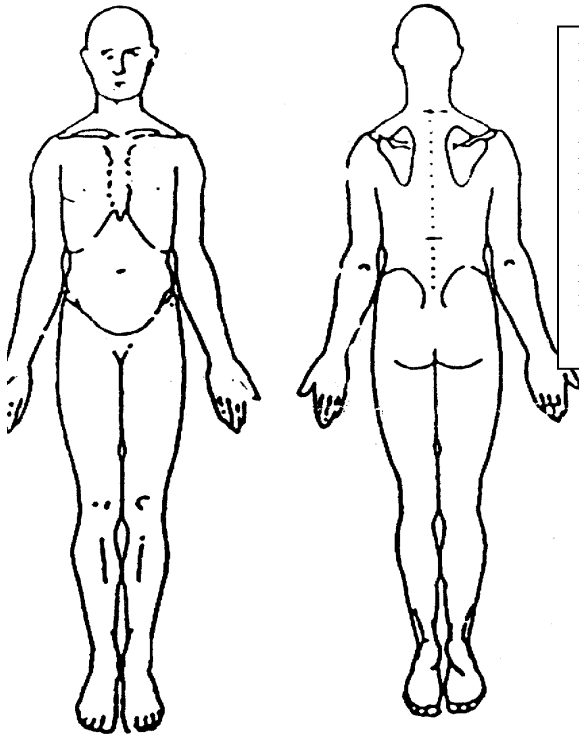
**Have you or any immediate family member ever been told you have . . .**

	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? .....
- Fever/Chills/Sweats? .....
- Unexplained weight change? .....
- Numbness or tingling? .....
- Changes in appetite? .....
- Difficulty swallowing? .....
- Changes in bowel/bladder function? .....
- Shortness of breath? .....
- Dizziness? .....
- Upper respiratory infection? .....
- Urinary tract infection? .....

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** \_\_\_\_\_