

Oconee Physical Therapy and Sports Rehabilitation

Past Medical History Form

Patient Name: _____ Date Completed: _____ Age: _____

MEDICAL HISTORY:

Right / Left Handed Male / Female

Height: _____ Weight: _____

Next Doctor Visit: _____

•What is the problem you are here for?

•Date of injury or when pain started:

•Date of Surgery (if applicable): _____

•Check which apply to your injury:

- Work-related
- Motor vehicle accident
- Athletic / recreational injury
- Injury related to lifting or falling
- Recurrence of previous injury
- Cause unknown
- Other: _____

•Is this the first time you have had this pain? yes/no If NO, then when: _____

•What treatments have you tried?
Medications, Physical Therapy, Massage,
Chiropractic, Surgery

•What medications are you taking? _____

SOCIAL HISTORY:

Do you Smoke? YES NO Drink Alcohol? YES NO

Married? YES NO Children? NO YES # _____

Do you regularly exercise? YES NO

WORK HISTORY:

•Are you employed? Yes NO

•Are you presently working? YES NO
IF NO, then date of last work day: _____

•Current Occupation: _____

•Where are you employed: _____

PAST MEDICAL HISTORY:

•Check which apply:

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | |

Other: _____

•Female: Are you Pregnant? YES NO

•Indicate Surgeries and date or year: _____

•Check which apply:

- | | |
|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Change in bathroom habits | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Significant Weight loss | |

Other: _____

PAIN AND SYMPTOMS: Circle the answer:

•Is your pain? Occasional Continuous

•When is your pain the worst?
Morning, Afternoon, Evening, Nighttime

•When is your pain the best?
Morning, Afternoon, Evening, Nighttime

•Can you sleep? YES NO

•What is your best sleeping position?
Side, Back, Stomach, Other, _____

•Circle the number that rates your pain *right now*:
None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

•Circle the number that rates you pain *at worst*:
None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

•Circle the number that rates you pain *at best*:
None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

Please check the answers that apply to you.

•What makes your pain better?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> sitting | <input type="checkbox"/> standing in one place | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> walking | <input type="checkbox"/> bending backward | <input type="checkbox"/> laying flat |
| <input type="checkbox"/> bending forward | <input type="checkbox"/> other: _____ | |

•What makes your pain worse?

- sitting
- standing in one place
- walking
- driving
- bending forward/backward
- sleeping, laying flat
- reaching above your head
- walking up / down stairs

Mark where your symptoms are.

