HSHS St. Anthony's Memorial Hospital

Patient Name: _____

# MEDICAL HISTORY FORM

Diagnosis as stated to you by your physician: _____ Date of onset: _____
How did this injury/exacerbation occur? _____
Have you been hospitalized for the present condition? ☐ Yes ☐ No If Yes, date: _____
Have you had surgery for the present condition? ☐ Yes ☐ No If Yes, date: _____
Have you received previous treatment for this condition? ☐ Yes ☐ No If Yes, date: _____
If Yes, please summarize: _____
What would you say is the pain rating for your current condition using a scale of 0-10?
(0=no pain, 10=worst pain imaginable) _____

| Do you now or have you ever had the following? | | | Explain |
|---|---|---|---|
| *Stroke* | ☐ *Yes* | ☐ *No* | _____ |
| *Heart Disease or Heart Murmur* | ☐ *Yes* | ☐ *No* | _____ |
| *High Blood Pressure* | ☐ *Yes* | ☐ *No* | _____ |
| *Asthma* | ☐ *Yes* | ☐ *No* | _____ |
| *Diabetes* | ☐ *Yes* | ☐ *No* | _____ |
| *Epilepsy/Fainting* | ☐ *Yes* | ☐ *No* | _____ |
| *Impairment of Vision or Hearing* | ☐ *Yes* | ☐ *No* | _____ |
| *Cancer* | ☐ *Yes* | ☐ *No* | _____ |
| *Drug Allergies* | ☐ *Yes* | ☐ *No* | _____ |
| *Osteoporosis* | ☐ *Yes* | ☐ *No* | _____ |

## Orthopedic History—Please give dates & treatments received:

Have you ever sprained, strained, dislocated, or fractured the following:
Neck/Head (Including concussion) _____
Trunk (ribs, vertebrae, sternum) _____
Low Back (vertebrae, discs, nerves) _____
Upper Extremity (shoulder, elbow, wrist, arm) _____
Lower Extremity (hip, leg, knee, ankle, foot) _____

Please list any surgeries that you have had and their dates:

_____

_____

Please list any medication(s) you are presently taking: _____

_____

Women: Are you pregnant? ☐ Yes ☐ No

I agree that the above information accurately describes my medical history and that should any changed in my medical history occur, I will notify my PT immediately.

Date: _____ Time: _____ Signature: _____

**Not part of permanent record. Please discard at discharge.**