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.

Form #7511-021

NEW 8/13