UPMC Centers for Rehab Services

Medical History Form

GENERAL INFORMATION

Name: _____
(last) (first) (middle initial)

Referring Physician: _____ Primary Care Physician:_____

Date of Birth: _____ Age: ____ Sex: ____ Height: ____ Weight: ____ BMI: ____

WHY ARE YOU SEEKING THERAPY?

_____

_____

On what date did this problem begin? _____ (please specify the **date of onset**)
If this is an ongoing condition, when did it get worse? _____(please specify the date of recurrence)

HISTORY OF PRESENT INJURY/ILLNESS

How did your injury or condition develop? _____

- ☐ Activities of Daily Living (please specify):_____
- ☐ Motor Vehicle Accident (please specify): _____
- ☐ Sports (please specify): _____
- ☐ Work (please specify): _____
- ☐ Following Surgery (please specify): _____
- ☐ Following an Illness (please specify): _____
- ☐ Other (please specify): _____

As a result of your current health condition, are you presently receiving Workers' Compensation? ☐ **Yes** ☐ **No**

Is your current health condition the subject of litigation other than Workers' Compensation? ☐ **Yes** ☐ **No**

HAVE YOU HAD TREATMENT FOR THIS PROBLEM IN THE PAST? ☐ Yes ☐ No

☐ Physical Therapy	☐ Massage Therapy	☐ Alternative Medicine
☐ Occupational Therapy	☐ Speech Therapy	☐ Other:_____
☐ Chiropractor	☐ Pain Clinic	☐ Other: _____

Are you currently receiving Home Care services? ☐ **Yes** ☐ **No**

WITHIN THE PAST YEAR, HAVE YOU HAD ANY OF THE FOLLOWING TESTS? ☐ Yes ☐ No

If yes, please check all that apply.

☐ Arthroscopy	☐ CT Scan	☐ MRI	☐ Stress test	☐ Other _____
☐ Biopsy	☐ Doppler/Ultrasound	☐ Myelogram	☐ Vestibular	☐ Other _____
☐ Bone Scan	☐ EMG/NCV	☐ Spinal tap	☐ X-ray	☐ Other _____

HEALTH HISTORY INFORMATION:

The following is a list of common health problems. Please indicate those problems you currently have or have had in the past and include the approximate date. **Check only those that apply to you.**

Medical Problem	Problems You Have or Had in the past		Medical Problem	Problems You Have or Had in the past	
Abdominal Pain/Problems	☐	Date:	High blood pressure	☐	Date:
Alcohol or Drug Abuse	☐	Date:	Intravenous Drug Use	☐	Date:
Anemia or other Blood Disease	☐	Date:	Joint Replacement	☐	Date:
Angina (chest pain)	☐	Date:	Kidney or Liver Disease	☐	Date:
Anxiety, Depression, or Panic Attacks	☐	Date:	Lung disease	☐	Date:
Arthritis	☐	Date:	Multiple Sclerosis (M.S.)	☐	Date:
Asthma	☐	Date:	Muscle, Bone, or Joint Injury	☐	Date:
Bowel or Bladder Irregularities	☐	Date:	Osteoporosis	☐	Date:
Cancer	☐	Date:	Pacemaker	☐	Date:
Carpal Tunnel Syndrome	☐	Date:	Parkinson's disease	☐	Date:
Circulatory problems	☐	Date:	Persistent fever	☐	Date:
Congestive Heart Failure	☐	Date:	Phlebitis/blood clots	☐	Date:
Diabetes	☐	Date:	Pregnant _____ weeks	☐	Date:
Epilepsy or Seizure Disorder	☐	Date:	Psychological treatment	☐	Date:
Fainting, Dizziness, or Vertigo	☐	Date:	Skin disease	☐	Date:
Fibromyalgia	☐	Date:	Stress	☐	Date:
Fractures/broken bones	☐	Date:	Stroke/mini stroke	☐	Date:
Frequent falls*	☐	Date:	Thyroid	☐	Date:
Gastrointestinal problems	☐	Date:	TMJ	☐	Date:
Gout	☐	Date:	Tobacco Use	☐	Date:
Headache or migraines	☐	Date:	Tumors	☐	Date:
Hearing problems (loss, aids)	☐	Date:	Urinary Tract Infection	☐	Date:
Heart attack	☐	Date:	Unexplained weight loss	☐	Date:
Heart disease	☐	Date:	Use of Immunosuppressive Drugs	☐	Date:
Heart surgery	☐	Date:	Vision problem (loss, blurring, glasses, etc.)	☐	
Other:			Last Visual Exam:		Date:

* If you indicated Frequent falls, how many have you have had in the last year and please describe any injuries related to falls:

_____

Have you had a physical examination by your doctor in the past year? ☐ **Yes** ☐ **No**

Comments:_____

PLEASE LIST ANY MAJOR SURGERIES/HOSPITALIZATIONS:

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

PLEASE LIST ANY KNOWN ALLERGIES:

_____

_____

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBAL) WHICH YOU ARE CURRENTLY TAKING:

_____

_____

_____

Patient Name: **DOB:**

SINCE THE ONSET OF YOUR PROBLEM, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

☐ Balance difficulties	☐ Pain at rest	☐ Tingling, numbness, or loss of feeling
☐ Blurred or double vision	☐ Pain with exercise/exertion	☐ Tremors (shaking)
☐ Bowel/bladder habit changes	☐ Pain unrelieved by rest or movement	☐ Unexplained weight loss
☐ Calf pain with exercise	☐ Shortness of breath	☐ Unusual weakness or fatigue
☐ Chest pain, pressure, or tightness	☐ Speech pattern changes	☐ Wound that does not heal
☐ Dizziness	☐ Swallowing difficulties	☐ Walking difficulties
☐ Fainting or "black outs"	☐ Swollen hands, feet, ankles or legs	☐ Other (please explain): _____

LIVING ENVIRONMENT

Do you have help at home? ☐ **Yes** (please specify):_____ ☐ **No**

Are you having any difficulties with managing your activities of daily living or personal matters? ☐ **Yes** ☐ **No**

What type of residence?

☐ Private Home or Condominium	☐ Private Apartment	☐ Assisted Living
☐ Personal Care Home	☐ Group Home	☐ Other:_____

Does your home have: (check all that apply)

☐ Stairs - no railing ☐ Stairs with railing ☐ Elevator ☐ Ramp(s) ☐ Stair glide ☐ Other:_____

Do you own/use any of the following? (please check all that apply)

☐ Crutches	☐ Cane (quad or straight)	☐ Walker	☐ Walker with wheels
☐ Wheelchair (manual)	☐ Wheelchair (powered)	☐ Scooter (motorized)	☐ Other:_____

EMPLOYMENT/WORK

What is your current work status? Check the **one** category that best describes your current work status.

☐ Work Regular Duty – Full Time	☐ Retired (Not due to health status)
☐ Work Regular Duty – Part Time	☐ Plan to Retire (please specify:_____)
☐ Work Light Duty/Modified Position – Full Time	☐ Unemployed
☐ Work Light Duty/Modified Position – Part Time	☐ Homemaker (Not working outside the home)
☐ Temporarily Unable to Work Due to Health Status	☐ Student (Not currently working)
☐ Permanently Unable to Work or Retired Due to Health Status	☐ Caregiver in home environment

Occupation: _____

VOCATIONAL COUNSELING SERVICES

Are you concerned about your ability to return to work? ☐ **Yes** ☐ **No**

Would you like a consultation with a Vocational Counselor? ☐ **Yes** ☐ **No**

I, the undersigned, state that I have answered this questionnaire to the best of my knowledge.

_____ _____

Patient Signature **Date**

Thank you for taking the time to provide us with this valuable information. It will help us to better serve you.

The following is to be completed by the Therapist

☐ **I have reviewed the Past Medical History and have made comments and/or referrals, when applicable.**

Therapist Signature: _____ **Date:** _____