McCullough-Hyde MEMORIAL HOSPITAL

A tradition of caring. A new vision of health.

Place chart sticker here

Physical Therapy Medical History

Date of Injury / Onset ___/___/___	**Date of Surgery**: ___/___/___	**Date of last physical exam** ___/___/___

List any medications you are currently taking

1	2	3	4
5	6	7	8

Have you had previous surgeries? What / where?

Circle Yes or No…

Have you or any immediate family member ever been told that 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

In the past 3 months have you had or do you experience:

A change in your health? ……	Yes	No
Loss of strength or energy? ……..	Yes	No
Nausea/Vomiting? …….	Yes	No
Fever/chills/sweats? ……..	Yes	No
Unexplained weight change? …….	Yes	No
Numbness or tingling? ……	Yes	No
Changes in appetite? ……..	Yes	No
Difficulty swallowing? ……..	Yes	No
Changes in bowel or bladder function? …….	Yes	No
Menstrual irregularities? ……	Yes	No
Shortness of breath? ……	Yes	No
Dizziness? ……	Yes	No
Upper respiratory infection? ……	Yes	No
Urinary tract infection? ……..	Yes	No
Often been bothered by feeling down, depressed or hopeless ?……..…	Yes	No
Been bothered by little interest or pleasure in doing things? …….	Yes	No

Are you currently:

Pregnant? …….	Yes	No
Depressed? ……..	Yes	No
Under stress? ……..	Yes	No

Check all that apply… I currently have difficulty:

☐ Driving ☐ Getting up from a chair
☐ Walking ☐ Bending at the waist
☐ Standing ☐ Lifting
☐ Walking up stairs ☐ Walking down stairs

If you are accustomed to regular exercising check the ones that give you difficulty now:

☐ Playing sports ☐ Running ☐ Walking ☐ Exercise

Circle Yes or No

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
Testing positive for tuberculosis? ……..	Yes	No
Living with someone who had tuberculosis?	Yes	No

Are your symptoms (check one):

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night (check one)?

☐ Fine ☐ Moderate difficulty ☐ Only with medication

Do you have a problem with…(check all that apply)

☐ Hearing ☐ Vision ☐ Speech ☐ Communication

How do you learn best?

☐ Seeing ☐ Doing ☐ Hearing

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, _____X per week.

Pain

What is your current level of pain on a scale of 0 to 10 (**circle one**)? 1 2 3 4 5 6 7 8 9 10 (0=no pain; 10=go to hospital)
What makes the pain worse?
What makes the pain better?

Is your pain (check one)

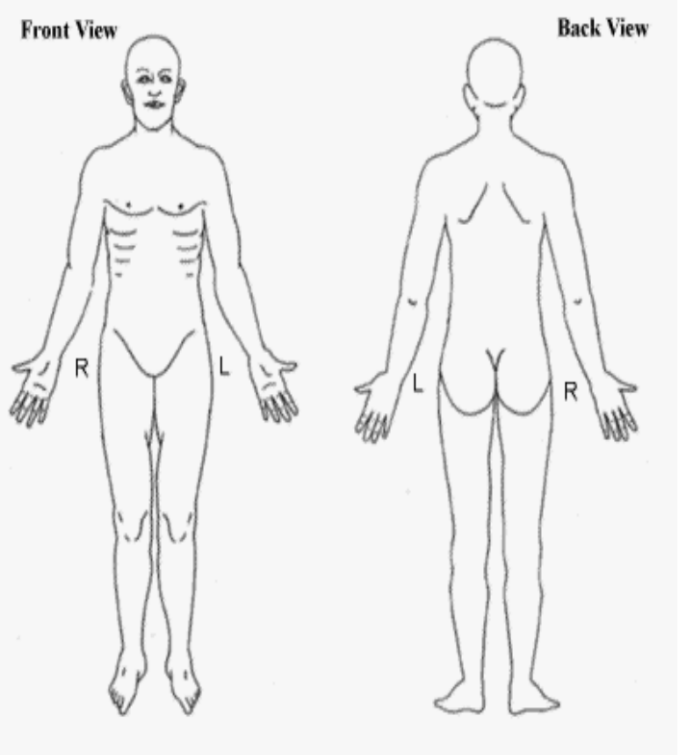
- ☐ A- constant (never goes away)
- ☐ B- intermittent (relieved with some positions or rest)
- ☐ C- occasionally (daily or less frequent)
- ☐ D- infrequently (once a week or month)
- ☐ **E** - previously (no longer present)
- ☐ **F** - variable (sometimes worse than other times)

Instructions

1. Draw each area of your pain or other symptoms onto the chart.

2. Choose the corresponding number and letters from the previous lists to describe your symptoms or use your own words.

3. Put the date of each area of symptoms started <u>for this episode</u> to the best of your memory.



To the best of my ability, I have given and included all pertinent medical information.

Patient Signature / Date	**Reviewed by / Date**

7/09.