

Industrial Hand and Physical Therapy

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____
 Family Physician: _____ Date of First Doctor Visit for this Injury: _____
 Last Date Worked Due to this Injury: _____ Date Returned to Work After Injury: _____
 Is an Attorney Involved in this Case? Yes No
 Have you had Surgery for this Injury? Yes No Number of Surgeries? _____
 Type of Surgery: _____

Are You Currently Taking Any Prescriptions or Non-Prescription Medications? Yes No
 Anti-inflammatories _____ **List Medications** _____
 Muscle Relaxers _____
 Pain Medication _____

Hand Dominance: Right Left

Have you had any of the following Medical or Rehabilitative Services for the Injury / Episode?

	YES	NO		YES	NO
X - Rays			Chiropractor		
EMG / NCV			General Practitioner		
CT Scan			Neurologist		
MRI			Orthopedist		
Myelogram			Podiatrist		
Physical Therapy			Occupation Medicine Doctor		
Occupational Therapy			Emergency Room Care		
Massage Therapy			Other: _____		

Do you now have, or have you ever had **ANY** of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema			Severe or Frequent Headaches		
Tuberculosis			Vision or Hearing Difficulties		
Infectious Diseases			Dizziness or Fainting		
Shortness of Breath / Chest Pain			Numbness or Tingling		
Coronary Heart Disease or Angina			Neck Injury or Surgery		
Heart Attack or Surgery			Back Injury or Surgery		
Do you have a pacemaker?			Shoulder Injury / Surgery		
High Blood Pressure			Elbow / Hand Injury / Surgery		
Stroke / TIA			Knee Injury / Surgery		
Blood Clot / Emboli			Leg / Ankle / Foot Injury / Surgery		
Epilepsy / Seizures			Any Pins or Metal Implants		
Sleeping Problems / Difficulties			Joint Replacement		
Emotional / Psychological Problems			Arthritis / Swollen Joints		
Anemia			Osteoporosis		
Diabetes			Gout		
Thyroid Trouble / Goiter			Varicose Veins		
Cancer			Hernia		
Allergies			Weakness		
Bowel or Bladder Problems			Are you Pregnant?		
Weight Loss / Energy Loss			Do You Smoke?		

List any other information that would assist us in your care: _____

Are you aware of what your diagnosis is? Yes No
 Base upon you awareness, what are your expectations / goals while in this program? _____

Patient / Guardian Signature: _____

I have reviewed this medical history with the patient.

Therapist Signature: _____