ORTHOPEDIC ASSOCIATES PHYSICAL THERAPY

MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Date of Injury/Onset:_____
Allergies:_____
Emergency Contact: _____ Phone _____
Are you pregnant? Y / N Please list any test results (X-ray, MRI, etc):_____
Referring MD:_____ Primary Care MD: _____Tel:_____
Current Medications: □ None □ Please list: _____
_____
Other MD/phone (Please list *any* other MD who is prescribing or who you are receiving care from):_____
_____

Do you have any past or present history of:	**Yes**	**No**
Heart Disease, High Blood Pressure, Angina, Pacemaker?	_____	_____
Respiratory Problems, Asthma, Allergies, TB?	_____	_____
Diabetes (Any type)?	_____	_____
Arthritis(Diagnosed by M.D.)?	_____	_____
Bone Disease(s)	_____	_____
Skin Disorders, Eczema, Psoriasis, Athlete's foot?	_____	_____
Communicable Diseases, hepatitis, TB?	_____	_____
History of Cancer (Any type)?	_____	_____
Any metal or artificial implants?	_____	_____
Any previous injuries to the same area?	_____	_____
Any previous motor vehicle accidents with injuries?	_____	_____
Any previous surgeries?	_____	_____
Any history of seizures or epilepsy?	_____	_____
Do you have any latex allergies?	_____	_____

Please explain any YES answers and state date of occurrence: _____
_____
_____
_____

In the diagram on the right, please mark the area(s) where your pain is located using the following symbols:

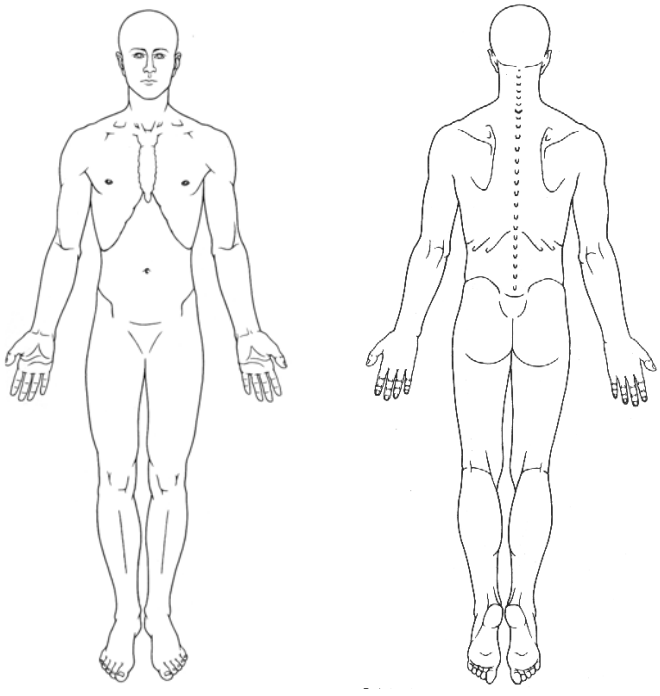
X = PAIN
/// = PINS AND NEEDLES
O = NUMBNESS
↓ = SHOOTING PAIN

Please rate your pain right now on a scale of 0 – 10 with 0 being no pain at all and 10 being the worst pain imaginable:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
What would you rate your pain at its lowest? /10
What would you rate your pain at its highest? /10

Please describe your pain (circle all that apply).
constant intermittent sharp dull aching burning

tingling stabbing throbbing shooting cramping



Do you have a Do Not Resuscitate (DNR) Order?
Yes_____ If yes, please notify your therapist.
No_____
THANK YOU!

Signature: _____ **Date:** _____

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