# Medical History Form

*Welcome to Centennial Sports and Physical Therapy. Please take a moment to complete your medical history as* ***accurately*** *as possible. This information allows us to provide you with the most efficient and effective care specific to your personal needs. Thank You*

Name: Age: Occupation: \_\_\_\_\_\_

Date of injury/onset: \_\_\_\_\_\_\_\_\_\_\_Leisure activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you injured? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Chief Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries related to this injury? [ ]  No [ ]  Yes procedure: Date of Surgery:

Please list any surgeries or other conditions that we should be aware of: \_\_\_\_\_\_

Tests (X-ray, MRI):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **sensitive to latex?**  [ ]  Yes [ ]  No Do you have a **Pacemaker**? [ ]  Yes [ ]  No

Do you **Smoke**?[ ]  Yes [ ]  No

Do you **exercise** regularly? [ ]  Yes [ ]  No Times a week**\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Specific exercise\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever taken **steroid** medication for any medical conditions? [ ]  Yes [ ]  No Have you ever taken **blood thinning** or **anticoagulant** medications for any medical conditions? [ ]  Yes [ ]  No

**Have you RECENTLY noted any of the following** *(check all that apply)*?

[ ]  Balance issues while walking

[ ]  Bowel / Bladder changes

[ ]  Constipation

[ ]  Cough

[ ]  Diarrhea

[ ]  Difficulty swallowing

[ ]  Dizziness / Lightheadedness

[ ]  Fainting

[ ]  Falls

[ ]  Fatigue

[ ]  Fever / Chills / Night sweats

[ ]  Headaches

[ ]  Heartburn / Indigestion

[ ]  Nausea or vomiting

[ ]  Numbness or tingling

[ ]  Shortness of breath

[ ]  Vision or hearing problems

[ ]  Weakness

[ ]  Weight loss or gain

**Have you EVER been diagnosed with any of the following conditions** *(check all that apply)*?

[ ]  Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Anemia

[ ]  Arthritis

[ ]  Asthma

[ ]  Bladder/Urinary tract infection

[ ]  Blood Clots

[ ]  Bowel or bladder problems

[ ]  Bone or joint infection

[ ]  Cancer

[ ]  Chemical dependency

[ ]  Chest pain / Angina

[ ]  Circulation problems

[ ]  Depression

[ ]  Diabetes

[ ]  Emphysema / Bronchitis

[ ]  Eye problems / Infection

[ ]  Fibromyalgia

[ ]  Heart Problems

[ ]  Hepatitis

[ ]  High blood Pressure

[ ]  Kidney Disease

[ ]  Liver problems

[ ]  Lung problems

[ ]  Multiple Sclerosis

[ ]  Numbness or tingling

[ ]  Osteoporosis / Osteopenia

[ ]  Pelvic inflammatory disease

[ ]  Reproductive condition/Change

[ ]  Seizures

[ ]  Stroke

[ ]  Thyroid problems

[ ]  Ulcers

[ ]  Other:

During the past month have you been feeling down, depressed or hopeless? [ ]  Yes [ ]  No

During the past month have you been bothered by having little interest or pleasure in doing things? [ ]  Yes [ ]  No

Is this something with which you would like help? [ ]  Yes [ ]  Yes, but not today [ ]  No

Are you currently taking any **medications**? ***(Please list or attach a list)***

Please use the diagram below to mark where you feel your symptoms and comment as you see appropriate, on the space provided

My symptoms currently: [ ]  Come & Go [ ]  Are Constant [ ]  Are constant but change with activity

My symptoms are currently: [ ]  Getting better [ ]  Getting Worse [ ]  Staying about the same

**How are you currently able to sleep at night due to your symptoms**?

[ ]  No problem sleeping [ ]  Difficulty falling asleep [ ]  Awakened by pain [ ]  Sleep only with medication

When are your symptoms worst? [ ]  Morning [ ]  Evening [ ]  Night [ ]  At rest [ ]  After Exercise

When are your symptoms best? [ ]  Morning [ ]  Evening [ ]  Night [ ]  At rest [ ]  After Exercise

Are there any other activities you are unable to do or are having difficulty with as a result of your problem? List & rate on the scale: **(Unable to perform** 0 1 2 3 4 5 6 7 8 9 10 **(Able to perform activity at pre-injury level)**

1) Rating: \_\_\_\_\_\_\_\_

2) Rating: \_\_\_\_\_\_\_\_

3) Rating: \_\_\_\_\_\_\_\_

 Patient Specific Functional Scale (PSFS) Avg: \_\_\_\_\_\_\_

How did you decide to attend Centennial Sports and Physical therapy?

\_\_\_Doctor \_\_\_Return Client \_\_Friend or Relative \_\_\_Advertisement Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_