# 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

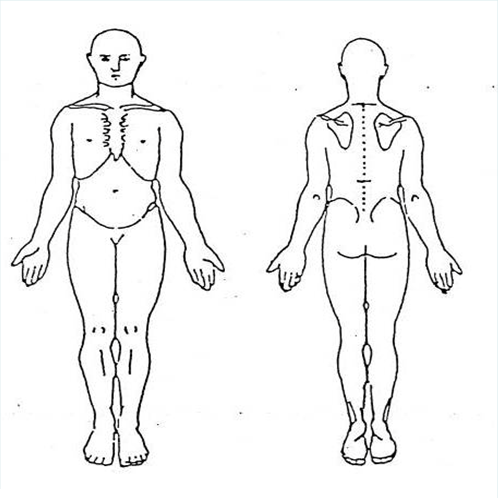
Other:

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_