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-Perscription Medications? Yes No

Anti-inflammatories ________ **List Medications** ______________________

Muscle Relaxers ________ ______________________

Pain Medication ________ ______________________

What is your dominant hand? 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 Breadth / 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			Vericose 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: ______________________

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Are you aware of what your diagnosis is? Yes No

Base upon you awareness, what are your expectations / goals while in this program? __________

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Patient / Guardian Signature: ______________________

I have reviewed this medical history with the patient.

Therapist Signature: ______________________