

Modical History Form

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Medical History Form			in partnershi		Medical	
Patient Name:	Account Number:					
Height:ftin We	eight:ftin Weight:(pounds) Date of injury:					
Diagnosis as stated to you by you	^r physicia	n:				
How did this injury/ exacerbation o	ccur?					
Have you been hospitalized for the	e present	conditio	n? □ Yes □ No If Yes, date: _			
			□ Yes □ No If Yes, date:			
If yes, surgery type:						
			If Yes, how many?			
Have you received previous treatn	nent for th	nis condi	tion? □ Yes □ No If Yes, date:			
If yes, please summarize:						
Have you ever had any of the follo	wing? 🗆	EMG	□ CT SCAN □ MYELOGRAM	□ MRI	□ XRA	
Have you ever, or are you present	•					
Acquired Respiratory Distress			Allergies	□ Yes	□No	
Syndrome	□ Yes	□No	Headaches	□ Yes	□No	
Angina	□ Yes	□No	Back Injury	□ Yes	□No	
Anxiety or Panic Disorders	□ Yes	□No	Bleeding Disorders	□ Yes	□No	
Arthritis (RA, OA)	□ Yes	□No	Bowel / Bladder Abnormalities	□ Yes	□No	
Asthma	□ Yes	□No	Cancer	□ Yes	□No	
Chronic Obstructive Pulmonary			COVID-19	□ Yes	□No	
Disease (COPD)	□ Yes	□No	If Yes, Date:	<u> </u>		
Congestive Heart Failure (CHF)	□ Yes	□No		- Vaa	-Na	
Degenerative Disc Disease			Dizzy or Fainting Spells	□ Yes	□No	
(back disease, spinal stenosis,	□ Yes	□No	Epilepsy or Seizure Disorder Fracture	□ Yes	□No	
severe chronic back pain)				□ Yes	□No	
Depression	□ Yes	□No	Hepatitis A, B, C	□ Yes	□No	
Diabetes	□ Yes	□No	Hernia	□ Yes	□No	
Emphysema	□ Yes	□No	High Blood Pressure	□ Yes	□No	
Hearing Loss or Deafness	□ Yes	□No	HIV/AIDS	□ Yes	□No	
Heart Attack	□ Yes	□No	Hypoglycemia	□ Yes	□No	
Multiple Sclerosis	□ Yes	□No	Immunosuppressant Condition or	□ Yes	□No	
Osteoporosis	□ Yes	□No	Medication	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
Parkinson's Disease	□ Yes	□No	Kidney Problems	□ Yes	□No	
Peripheral Vascular disease	□ Yes	□No	Liver / Gallbladder Problems	□ Yes	□No	
Stroke or TIA	□ Yes	□No	Metal Implants	□ Yes	□No	
Upper Gastrointestinal Disease	□ Yes	□No	Nausea / Vomiting	□ Yes	□No	
(ulcer, hernia, reflux)			Pacemaker	□ Yes	□No	
Visual Impairment	Vaa	NI -	Defibrillator	□ Yes	□No	
(cataracts, glaucoma, macular	□ Yes	□No	Pregnancy	□ Yes	□No	
degeneration)	1		Ringing in Your Ears	□ Yes	□No	
			Sexual Dysfunction	□ Yes	□No	
			Skin Abnormalities	□ Yes	□No	
			Smoking	□ Yes	□No	
			Special Diet Guidelines	□ Yes	□No	
			Tuberculosis	□ Yes	□No	





in partnership with Select Medical

			list (you may use reverse side):
Γο help us understand your	•		
My pain is worse: in the mo		-	•
On a scale of 0 to 10 (0 beir Please rate your pain at	its best and a		
	Pair	 n Diagram	
Using the ke	ey provided, please draw area of the body as it re	the symbol represent	
	Key		
	↑ or ↓ Radiating Pain XXX Spasm ZZZ Tenderness	//// Numbness, 000 Ache/Pain	/Tingling
·		•	ıld know about?