

Past Medical History

STAFF ONLY

Patient Identification Number	Date: MM/DD/YYYY	Payer Source	Patient Proxy, if applicable
Primary Clinician	Body Part	Multi <input type="checkbox"/>	Impairment Category
Patient Name (Last Name, First Name)		Birth Date: MM/DD/YYYY	Male <input type="checkbox"/> Female <input type="checkbox"/>

PATIENT PORTION

1. How many days ago did this condition begin?

0-7 8-14 15-21 22-90 91-6 mo. More than 6 mo.

2. Date of injury: _____

3. Date of next physician's visit: _____

4. Have you had a related injury?

Yes No

5. Have you ever had these symptoms before?

Yes No

6. Height _____

7. Weight _____

8. If female, are you pregnant? Yes No

9. What is your present employment status? (Mark ONE response only)

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Employed-presently working full duty at same job | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed-presently working full duty at different job | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Employed-presently working restricted duty at same job | <input type="checkbox"/> Student |
| <input type="checkbox"/> Employed-presently working restricted duty at different job | <input type="checkbox"/> Other |
| <input type="checkbox"/> Employed-presently not working due to my condition | |
| <input type="checkbox"/> Previously employed-receiving disability benefits for my condition | |

10. Indicate the number of surgeries for your primary condition: 0 1 2+

11. Have you received treatment for this condition before? Yes No

If yes, what type of treatment did you have? _____

12. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to the onset of your condition?

At least 3 times/week Once or twice/week Seldom or never

13. I should not do physical activities which might make my pain worse:

0- Completely disagree 1 2 3-Unsure 4 5 6- Completely Agree

14. Please indicate the average pain you have had in the last 24 hours by circling the number:

No Pain _____ As bad as it can be
 0 1 2 3 4 5 6 7 8 9 10

15. Are you taking prescription medication for this condition? Yes No

16. Please list ANY medications you are taking and what they are for: _____

17. Please list any known allergies: _____

Generic/Cancer Rehab

21. How much does pain interfere with your normal work (including work outside the home, work around the yard and housework)?

Extremely_____

Quite A Bit_____

Moderately_____

Not At All_____

19. Other health problems may affect your treatment. Please check any of the following that apply:

___ Arthritis (Rheumatoid/Osteo)

___ Headaches

___ Pain interferes with sleep

___ Osteoporosis

___ Seizures

___ Incontinence

___ Asthma/Breathing Difficulties

___ Dizziness/Fainting

___ Fractures

___ COPD, ARDS or Emphysema

___ GI Disease (Ulcer, Hernia

___ Skin Abnormalities

___ Angina/Chest Pain

(Reflux, Bowel, Liver Gall Bladder)

___ Anxiety/Panic Disorders

___ Congestive Heart Failure

___ Visual Impairment (Cataracts,

___ Depression

(or Heart Disease)

Glaucoma, Macular Degeneration)

___ Other Disorders

___ Heart Attack (or MI)

___ HOH, even with hearing aids

___ Hepatitis/AIDS

___ Heart Palpitations

___ Ringing in your ears

___ Prior Surgery

___ Pacemaker

___ Diabetes Type I or II

___ Prosthesis/Metal Implants

___ High Blood Pressure

___ Hypoglycemia

___ Sleep Dysfunction

___ Neurological Disease (such as

___ Back Pain (Neck, DDD, or

___ Cancer

MS or Parkinson's)

Spinal Stenosis)

___ Smoking

___ Stroke or TIA

___ Kidney, Bladder, Prostate or

___ Changes in bowel/bladder

___ Peripheral Vascular Disease

Urination Problems

function

Please add any details if you checked any of the above, and/or list any other pertinent information: _____

By signing this form, I acknowledge that the information is true and accurate to the best of my understanding.

Patient Signature_____ Date:_____

Witness Signature_____ Date:_____