**Rhode Island Rehabilitation**

REHABILITATION center

## PATIENT MEDICAL HISTORY FORM

Name: _____ Referring Physician (if any): _____

Have you had surgery for this injury? Y / N Is an attorney involved in this case? Y / N

Type of surgery: _____ Number of surgeries: _____

Is this a work-related injury? Y / N Date of injury or surgery: _____

**Are you currently taking any prescription or non-prescription medication? (Please list below)**

| | | |
|---|---|---|
| Anti-inflammatories | **Y / N** | _____ |
| Muscle relaxers | **Y / N** | _____ |
| Pain Medications | **Y / N** | _____ |
| Other medications | **Y / N** | _____ |

**Have you had any of the following services for this injury/episode?**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| General practitioner | ____ | ____ | CT Scan | ____ | ____ |
| Physical Therapist | ____ | ____ | X-Rays | ____ | ____ |
| Occupational Therapy | ____ | ____ | MRI | ____ | ____ |
| Massage Therapy | ____ | ____ | EMG/NCV | ____ | ____ |
| Chiropractor | ____ | ____ | Orthopedist | ____ | ____ |
| Podiatrist | ____ | ____ | Neurologist | ____ | ____ |

**Do you now or have you ever had any of the following?**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Asthma, Bronchitis or Emphysema | ____ | ____ | High Blood Pressure | ____ | ____ |
| Anemia | ____ | ____ | Shortness of Breath | ____ | ____ |
| Heart Attack or Surgery | ____ | ____ | Coronary Heart Disease | ____ | ____ |
| Diabetes/Metabolic Syndrome | ____ | ____ | Thyroid Dysfunction | ____ | ____ |
| Angina/Chest Pain | ____ | ____ | Gout | ____ | ____ |
| Cancer/Chemotherapy/Radiation | ____ | ____ | Dizziness/Fainting | ____ | ____ |
| Emotional/Psychological Issues | ____ | ____ | Infectious Diseases | ____ | ____ |
| Bowel/Bladder Problems | ____ | ____ | Weakness | ____ | ____ |
| Numbness or Tingling | ____ | ____ | Hernia | ____ | ____ |
| Severe or Frequent Headaches | ____ | ____ | Allergies | ____ | ____ |
| Vision or Hearing Problems | ____ | ____ | Arthritis | ____ | ____ |
| Neck or Back Injury/Surgery | ____ | ____ | Stroke/TIA | ____ | ____ |
| Knee or Hip Injury/Surgery | ____ | ____ | Blood Clot/Emboli | ____ | ____ |
| Ankle/Foot Injury/Surgery | ____ | ____ | Epilepsy/Seizures | ____ | ____ |
| Shoulder/Elbow/Hand Injury/Surgery | ____ | ____ | Varicose Veins | ____ | ____ |
| Do you have a Pacemaker? | ____ | ____ | Joint Replacement | ____ | ____ |
| Any pins or metal implants? | ____ | ____ | Weight loss/Energy loss | ____ | ____ |
| Are you pregnant? | ____ | ____ | Do you smoke? | ____ | ____ |

Other information that would assist us in your care: _____

Based on your diagnosis, what are your expectations/goals while in physical therapy treatment?

_____

**Patient/Guardian Signature:**_____ **Date:**_____/_____/_____

**Therapist Signature:**_____