REVOLUTION
REHABILITATION P.C.
PHYSICAL, ORTHOPEDIC & SPORTS THERAPY + WELLNESS

PATIENT MEDICAL HISTORY FORM

Please complete form in its entirety

Name:__________________________________ **Age**:________ **Height/Weight**:________________

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY: (Please put a check next to any condition that you have, and N/A next to those that you do not)

	High\Low Blood Pressure		Bowel or Bladder Problems		Asthma
	Abnormal Bleeding		Recent and sudden Weight Loss/Gain		Arthritis
	Heart Problem		Thyroid problems (Hyper or Hypo)		Emphysema
	Hearing problems		Diabetes(medication dependent **Yes** or **No**)		Dizziness
	High Cholesterol		Chronic heartburn/Intestinal upset		Night sweats
	Autoimmune disorder		Alcoholism\Chemical dependency		Pacemaker
	Headache\ Migraines		Cancer/tumors (where? ____________)		Chest pain
	Seizures/Epilepsy		Chronic Lung Problem		Ulcers
	Shortness of breath		Stroke\ Head\Brain Injury		Hernia
	Kidney Disease		Cataracts\ Glaucoma\ Macular degeneration		Blood clots

Please describe what we will be seeing you for today/when and how your symptoms began.

____

Do you have any known allergies? Please list. ____

Do you have any history of Hepatitis? (Please circle your answer) A B C NONE

Do you have any known disease or infection that can be transmitted through bodily fluids? YES/NO

Are you currently taking ANY form of blood thinners (this includes ibuprofen) YES/NO

Do you have a history of fractures? Yes or No? Where?

____

Do you smoke? Yes/NO How much per day? ____

Are you pregnant or suspect pregnancy? YES/NO

Do you feel safe at home? YES/NO

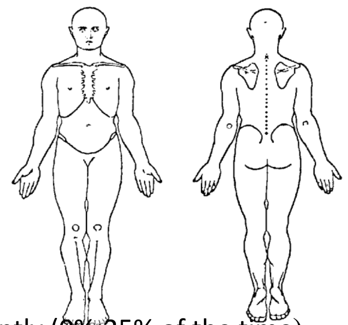
MEDICATIONS: ***Please list medications or we can photocopy your list for you.***

____

SURGERIES: ***Please list all surgeries, including date:***

____

PLEASE MARK WHERE PAIN IS



DIAGNOSTIC TESTS: Please check test(s) for current problem only.

( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density

( )Blood Chemistry ( )Ultrasound ( )Other (please specify)

HISTORY OF FALLS? YES/NO If Yes, when_________________________

Coordination or balance problems? YES/NO

Difficulty walking? YES/NO

Please rate your pain in this scale of 0-10. ***0=No Pain to 10=The Worst Pain***

Last 24 Hours: 0 1 2 3 4 5 6 7 8 9 10

Past week: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms: 1.Constantly (76%-100% of the time) 2.Frequently (51%-75% of the time)3. Occasionally (26% - 50% of the time) 4.Intermittently (0%-25% of the time)

I believe all information to be true and complete:

Signature: **Date:**