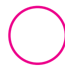
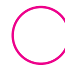
ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE
**Rehabilitation**



# PATIENT MEDICAL HISTORY



**Patient Name:** ______________________ ________ ______________________ **Email:** ______________________
FIRST MIDDLE LAST

## Medical Conditions:

Please check those you currently have or have had in the past *(provide specifics where applicable)*:

- ☐ Arthritis ____________________
- ☐ Asthma / Emphysema / COPD ____________________
- ☐ Blood Clot ____________________
- ☐ Bowel/Bladder ____________________
- ☐ Bronchitis ____________________
- ☐ Cancer ____________________
- ☐ Chest Pain ____________________
- ☐ Diabetes ____________________
- ☐ Dizziness ____________________
- ☐ Frequent Headaches ____________________
- ☐ Frequent Nausea ____________________
- ☐ Gout ____________________
- ☐ Hearing Loss ____________________
- ☐ Heart Condition ____________________
- ☐ Hernia ____________________
- ☐ High Blood Pressure ____________________
- ☐ Numbness / Tingling ____________________
- ☐ Osteoporosis (bone thinning) ____________________
- ☐ Pacemaker ____________________
- ☐ Seizures ____________________
- ☐ Sprains / Strains / Fractures ____________________
- ☐ Vision Disorders ____________________
- ☐ Other ____________________
- ☐ Other ____________________

## Hospitilization/Surgical History:

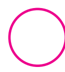
Please list all previous hospitilizations, sugeries/operations and serious illnesses:

| | HOSPITILIZATION/SURGERY/OPERATION | REASON | YEAR |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

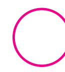
## Medications:

Please include prescriptions, non-prescription and herbal supplements:

| | DRUG NAME | DOSAGE | FREQUENCY | REASON FOR TAKING |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |



## PATIENT MEDICAL HISTORY



**Please indicate your functional limitations in the following areas:**

**Sitting longer than 15 minutes**

☐ None ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ N/A

**Standing longer than 15 minutes**

☐ None ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ N/A

**Walking longer than 15 minutes**

☐ None ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ N/A

**Lifting**

☐ None ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ N/A

**Sleeping**

☐ None ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ N/A

**Recreational Activities**

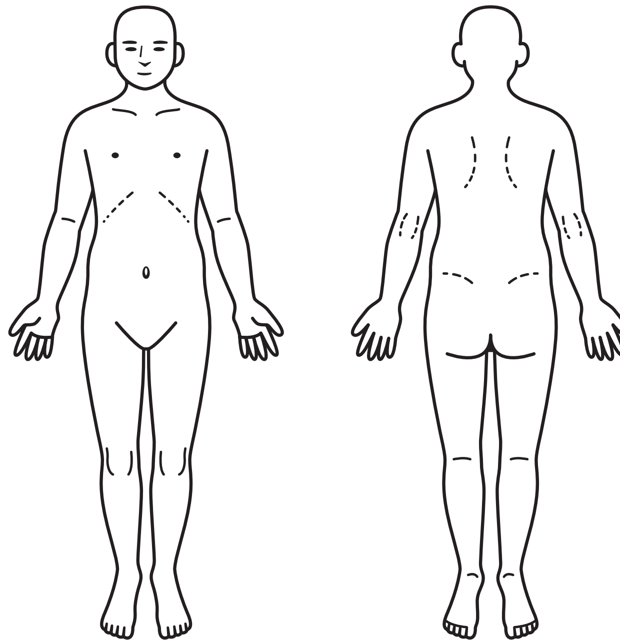
☐ None ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ N/A

**Work Activities**

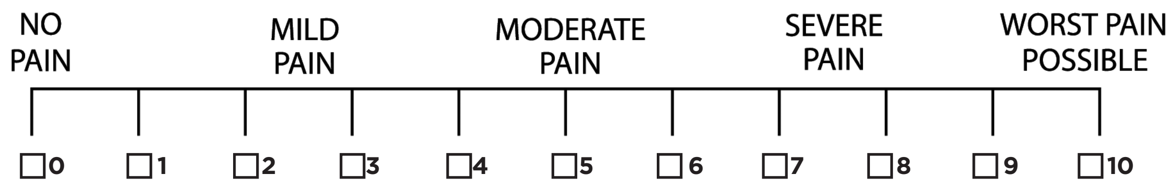
☐ None ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ N/A

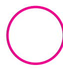
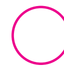
**PLEASE INDICATE BELOW WHERE YOUR PAIN IS LOCATED:**

*This may be filled out when you arrive at office.*



**CHOOSE A NUMBER 0 TO 10 THAT BEST DESCRIBES YOUR PAIN:**



## How do you prefer to learn new information?:

☐ Pictures

☐ Demonstration

☐ Verbally

## My goal for rehabilitation is:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## Social History:

OCCUPATION: ____________________________________________

| Employment | Dominant Hand | Are you Pregnant? |
|---|---|---|
| ☐ Retired | ☐ Right | ☐ Yes |
| ☐ Working Part-Time | ☐ Left | ☐ No |
| ☐ Full-Time | | |
| ☐ Student | | |

## Allergies:

**Please check those you currently have or have had in the past**:

☐ Adhesive

☐ Latex

☐ Lotions

☐ Other: __________________________

☐ Other: __________________________

**Agreement of Accuracy:** The information provided in this history form is true and complete to the best of my knowledge.

**Notice of Privacy Practices:** I am aware that Andrews Institute for Orthopaedics & Sports Medicine has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policies. I understand that a copy is available to me and I agree with these policies.

X____________________________________________ Date: ____________________