SPRING GROVE PHYSICAL MEDICINE & REHABILITATION

Health History Form – Page 1

Have you ever had any of the following medical conditions? Please circle yes or no. If yes, please explain.

Allergies or hayfever	**Yes**	**No**	
Alcohol/drug abuse	**Yes**	**No**	
Anemia	**Yes**	**No**	
Arthritis	**Yes**	**No**	
Asthma	**Yes**	**No**	
Cardiac condition – heart murmur, congenital defect	**Yes**	**No**	
Cancer	**Yes**	**No**	
Chronic bronchitis or emphysema	**Yes**	**No**	
Chest pain or angina	**Yes**	**No**	
Depression or psychological concerns	**Yes**	**No**	
Diabetes	**Yes**	**No**	
Firbromyalgia or chronic pain syndrome	**Yes**	**No**	
Guillian-Barre Syndrome	**Yes**	**No**	
Gout	**Yes**	**No**	
Head injury or concussion	**Yes**	**No**	
Heart attack	**Yes**	**No**	
Heart surgery or pacemaker	**Yes**	**No**	
Hemophilia or other blood disorder	**Yes**	**No**	
High blood pressure or hypertension	**Yes**	**No**	
HIV positive or AIDS	**Yes**	**No**	
Hypoglycemia	**Yes**	**No**	
Kidney disease or stones	**Yes**	**No**	
Liver disease (Hepatitis, jaundice, cirrhosis)	**Yes**	**No**	
Migraine Headaches	**Yes**	**No**	
Multiple Sclerosis	**Yes**	**No**	
Parkinson's Disease	**Yes**	**No**	
Polio	**Yes**	**No**	
Pneumonia	**Yes**	**No**	
Rheumatic Fever or Scarlet Fever	**Yes**	**No**	
Seizure Disorder or Epilepsy	**Yes**	**No**	
Shortness of breath	**Yes**	**No**	
Stroke or TIA (transient ischemic attack)	**Yes**	**No**	
Thyroid problems	**Yes**	**No**	
Tuberculosis	**Yes**	**No**	
Ulcers or other stomach problems	**Yes**	**No**	
Other (please specify)			

WOMEN ONLY:
ARE YOU PREGNANT? [ ] YES [ ] NO IF YES, HOW FAR ALONG: _____
NURSING? [ ] YES [ ] NO

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Health History Form - Page 2

Reason for this visit: (please circle) work, sports, auto, trauma, or chronic.
Please explain:

_____

_____

Please describe the pain and its location: _____

_____

When did this condition begin: _____/_____/_____
Is this condition interfering with your (please circle): work, sleep, or daily routine.
If yes, please explain: _____
Have you had this or similar conditions in the past: [ ] yes [ ] no
If yes, please explain: _____
Have you been seen elsewhere for this condition? _____

_____

What x-rays, scans, CTs, or MRIs have you had recently: _____
Results: _____
Goals for treatment: _____

_____

Known Drug Allergies:_____

_____

Smoking Status: [] never smoked, [] current dalily, [] current occasional, [] former smoker.
Please list all medications that you are currently taking (prescription, over the counter, and herbal products/supplements): _____

_____

_____

_____

List all previous operations/hospitalizations: _____

_____

List any past serious accidents with dates: _____

_____

Are you wearing: [ ] heel lifts, [ ] sole lifts, [ ] inner soles, [ ] arch supports, [ ] orthotics
What age is your mattress? _____ **Is it comfortable? [ ] yes [ ] no**
Have you had any illnesses in the last 3 weeks (cold, flu, urinary infection)? [ ]yes [ ]no
Do you have a pacemaker, implant, or organ transplant? [ ] yes [ ] no _____

Current occupation: _____

Does you job involve: [ ] prolonged sitting, [ ] prolonged standing,
[ ] prolonged walking, [ ] use of small equipment, [ ] use of large equipment,
[ ] frequent lifting, bending, climbing or turning, [ ] repetitive movement.

I understand the above information and guarantee this for was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.

Patient signature: _____**Date:** _____