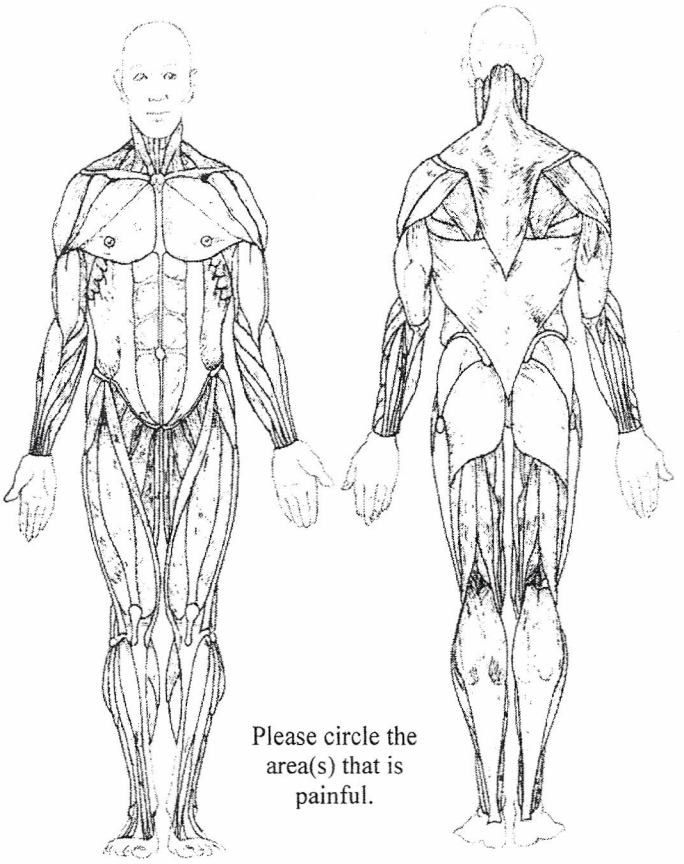
Patient Medical History

Your medical history is very important information for us to ensure your safety during your rehabilitation process. Please be as complete as possible with your answers, and feel free to discuss your history with your therapists

Do you have a history of the following?

	Yes	No
Diabetes		
Heart Disease		
Cardiac Pacemaker		
Cancer		
Stroke		
High Blood Pressure		
Gastrointestinal problems		
Lung Disease		



Please circle the area(s) that is painful.

Please list any significant surgeries you have had in the past five years:

_____

_____

_____

_____

Current Medication: _____

_____

What diagnostic test(s) have been performed for your current condition and where were they done?

__ X-ray __ MRI __ CT __ EMG/NCV __ Blood work Other: _____

Have you received physical or hand therapy for your current condition? __ Yes __ No

If Yes, When and where, and how long?

_____

_____

Have you experienced any of the following:

	Yes	No		Yes	No
Persistent pain at night			Frequent nausea or vomiting		
Fever or night sweats			Recent unexplained weight loss		
Are you pregnant			Frequent or severe abdominal pain		
Loss of appetite			Unusual menstrual irregularities		
Shortness of breath			Frequent heartburn or indigestion		
Dizziness					

Other medical history: _____

_____

_____

_____