ENGLEWOOD ORTHOPEDIC ASSOCIATES DEPT OF PHYSICAL AND HAND THERAPY MEDICAL HISTORY SCREENING FORM

NAME: _____ TODAY'S DATE: _____ DATE OF BIRTH: _____

Do you have ANY ALLERGIES to: MEDICATIONS? (please list) _____

FOODS? (list) _____ LATEX? YES NO ADHESIVES? YES NO

Do you have a PRIMARY PHYSICIAN? YES NO Name and City _____

Have you seen this physician or ANY OTHER health professional IN THE PAST 3 MONTHS? YES NO IF *YES*, PLEASE DESCRIBE THE REASON(S): _____

Do you have a PACEMAKER or DEFIBRILLATOR? YES NO

Please list *ANY* SURGERIES AND HOSPITALIZATIONS you have had, along with the APPROXIMATE DATES AND REASONS: _____

Circle YES or NO…

Have you or any immediate family members EVER been told you have:

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
Heart problems	Yes	No	Yes	No
Thyroid problems?	Yes	No	Yes	No
Depression?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Other arthritic conditions?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Angina/Chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Any other conditions?	Yes	No	Yes	No

In the past 3 months have you had or experienced:

A change in your health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?`	Yes	No
Difficulty swallowing/ speaking?	Yes	No
Changes in bowel or bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness, balance issues, or fainting?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No
Sexual dysfunction?	Yes	No

Circle YES or NO…

Do you have a history of:

Allergies/Asthma/ Bronchitis?	Yes	No
Headaches?	Yes	No
Tuberculosis?	Yes	No
Kidney disease?	Yes	No
Shingles?	Yes	No
Ulcers/ Abdominal pain?	Yes	No
Sexually transmitted diseases, HIV/AIDS, Hepatitis?	Yes	No
Seizures?	Yes	No
Stress?	Yes	No

For WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

During the past month, have you been feeling down, depressed or hopeless? YES NO

During the past month, have you been bothered by having little interest or pleasure in doing things? YES NO

Do you have a problem with: (check all that apply)

□ Hearing □ Vision
□ Speech □ Communication

Do you or have you in the past smoked tobacco? YES or NO

If yes, _____ Packs x _____ Years
Last tobacco use _____

Do you drink alcoholic beverages? YES or NO

If yes, how many drinks per average setting? _____
How many days a week do you drink? _____

ENGLEWOOD ORTHOPEDIC ASSOCIATES DEPT OF PHYSICAL AND HAND THERAPY SYMPTOMS FORM

Name _____ Date _____ Date of Birth _____

PAIN DESCRIPTION	
Please rate your pain 0 to 10 using the following scale: **0= No pain, 10= worst imaginable pain** **Current Level of Pain ___/10** **Worst pain in past 24 hours ___/10** **Past week ___/10** **Least pain in past 24 hours ___/10** **Past week ___/10** **Are your symptoms: (check one)** **□ Worsening □ Unchanging □ Improving**	**How are you able to sleep at night? (check one)** **□ Fine □ Moderate difficulty □ Only with medication** **What movements/positions make your symptoms worse? _____** **_____** **What movements/positions make your symptoms better? _____** **_____** **What is your occupation?** **_____** **What are your hobbies?** **_____**

Please list all current medications you are on, with the doses, frequency you take:

PRESCRIPTION **OVER THE COUNTER/SUPPLEMENTS**