MARYLAND SPORTSCARE & REHAB

Patient Questionnaire/Medical History Form

Under Medicare and the Maryland practice act we are required to obtain a complete medical history on all patients. This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Last Name: ________________________________ **First Name:** ________________________MI:_____ **Date:** ____/____/____

DOB: ____/____/____ Age: _______ Sex: M / F Hand Dominance: R / L Height: _________ Weight: ______________

How did you hear about us? ____

Family Doctor: ____ Referring Doctor: ______________________________________

If accident, circle place where occurred: Home Auto Work Sports Other Next Doctor's Visit: ____/____/____

Occupation: ________________________Current work status: ______________ **Do you have any lifting restrictions?** Y / N

Do you live alone? Y / N Are there stairs where you live? Y / N

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What is the reason for your visit today? ____

Briefly describe how your problem began: ____

What goals would you like to achieve through therapy?____

Date of onset/injury: ____/____/____ Date of surgery:____/____/____ Type of Surgery: ______________________________

Treatments for your current chief complaint have included: (Circle all that apply) ☐ No Treatment Received Yet

Physical Therapy	Chiropractic Care	Pain management	Mechanical Traction
Massage	Injections	Aquatic Therapy	Brace/Tape
Surgical Intervention	Personal Training	Athletic Training	Other: ________________________

Have any diagnostic tests have been performed for this problem? (circle all that apply)

X-rays Bone Scan Doppler Ultrasound MRI EMG CT Scan Bloodwork Other: _________________________

Please list body part tested and date tested: ____

Have you had similar symptoms in the past? Y / N Have you received Home Health PT prior to coming here? Y / N

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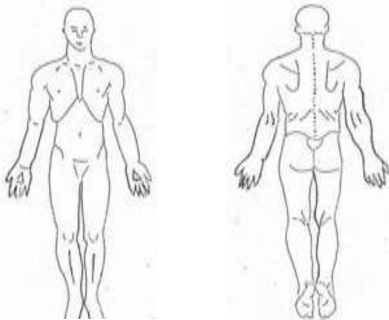
Please circle where you hurt:



Where did your pain start? ____

Since it started, pain is: ☐ getting worse ☐ improving ☐ the same

Describe pain: ☐ sharp ☐ dull ☐ aching ☐ sore ☐ throbbing ☐cramping

☐ burning ☐ shooting ☐ stabbing ☐squeezing ☐constant☐ intermittent

☐ other: ____

What makes it worse? ____

What makes it better? ____

Does time of day affect pain? ____

Does pain wake you from sleep? ____

Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):

Least: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Present: 0 1 2 3 4 5 6 7 8 9 10

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Do you have any tingling, numbness or loss of skin sensation? Y / N If so, where ? _______________________________

What increases this? _________________________________ What decreases this? ________________________________

Do you have any weakness? Y / N , where? ___________________________ How long has it been present? _____________

Do you have any swelling? Y / N , where? ____________________________How is it being managed?_________________

Have you had any recent falls? Y / N **Do you use any of the following:** Cane Walker Crutches Wheelchair

How would you rate your current health? ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor
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Please circle yes or no if you have or have had any of the following conditions:

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
Smoke/Chew Tobacco	Y / N	Diabetes	Y / N	Sexually Transmitted Disease	Y / N
packs per day: _____		Heart Attack	Y / N	Osteoarthritis	Y / N
Use of Illegal Substances	Y / N	Cardiac Bypass	Y / N	Rheumatoid Arthritis	Y / N
Drink Alcoholic Beverages	Y / N	Cardiac Stents	Y / N	Osteoporosis or Osteopenia	Y / N
amount per day: _____		Angina/Chest Pain	Y / N	Scoliosis	Y / N
High Blood Pressure	Y / N	Hepatitis	Y / N	Headaches or Migraines	Y / N
High Cholesterol	Y / N	Emphysema	Y / N	Dizziness or Fainting	Y / N
Bowel/Bladder Dysfunction	Y / N	COPD	Y / N	Cancer (site: ____________)	Y / N
Acid Reflux or Ulcers	Y / N	Asthma	Y / N	Recent Infection	Y / N
Thyroid Disorder	Y / N	Kidney Disease	Y / N	Recent Anticoagulant Medicine Use	Y / N
Bleeding Disorder	Y / N	Stroke	Y / N	Recent Antibacterial Medicine Use	Y / N
Seizures/Epilepsy	Y / N	Depression	Y / N	Consistent Steroidal Medicine Use	Y / N
Lyme Disease	Y / N	Lupus	Y / N	Multiple Sclerosis	Y / N
Pregnant (# wks_____)	Y / N	Fibromyalgia	Y / N	Congestive Heart Failure	Y / N

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Please circle yes or no if in the past 3 months have you experienced:

Symptom	Yes / No	Symptom	Yes / No
Persistent pain at night	Y / N	Change in or problems with bladder/bowel function	Y / N
Fevers, chills or night sweats	Y / N	Changes in hearing	Y / N
Unexplained weight loss	Y / N	Changes in mental abilities	Y / N
Unwarranted fatigue	Y / N	Frequent or severe headaches with no history of injury	Y / N
Unusual lumps or growths	Y / N	Problems with swallowing or changes in speech	Y / N
Pulsating pain anywhere in your body	Y / N	Changes in vision (blurriness or loss of sight)	Y / N
Constant and severe pain in leg or arm	Y / N	Problems with balance, coordination or falling	Y / N
Swelling without a history of injury	Y / N	Fainting spells/blackouts	Y / N
Shortness of breath	Y / N	Sudden unexplained weakness	Y / N
Frequent or severe abdominal pain	Y / N	Pain, tingling or numbness in and around your face	Y / N
Frequent nausea or vomiting	Y / N	Tingling or numbness in both of your arms or both legs	Y / N
Ringing in ears	Y / N	New moles or skin lesions	Y / N

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Please Circle any that you may have/wear: Glasses Contacts Dentures Pacemaker Metal Implant Hearing Aides

List all previous surgeries and dates: ____

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List all medications/supplements you are taking: ____

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List all allergies that you may have: ____

To the best of my ability, I have given and included all pertinent medical information.

Patient/guardian signature: ____ Date: ____/____/____

Medical history reviewed by physical/occupational therapist and used in determining the plan of care.

Therapist signature: ____ Date: ____/____/____