COMPREHENSIVE HAND AND PHYSICAL THERAPY
MEDICAL HISTORY FORM

PATIENT NAME: ___________________________ TODAY'S DATE: ___________________________

REFERRING PHYSICIAN'S NAME: ___________________________ DATE OF INJURY OR ONSET: ___________________________

PRIMARY CARE PHYSICIAN'S NAME: ___________________________ ARE YOU PRESENTLY WORKING? YES NO

CAUSE OF INJURY OR ONSET: ___________________________ DATE OF NEXT MD APPT: ___________________________

DO YOU CURRENTLY HAVE ANY “FLU TYPE” SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _______________________________________________________________

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: ___________________________

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: ________________

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO ____________________

WHAT IS YOUR REASON FOR ATTENDING THERAPY: ________________________________________________

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?
1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________

WHAT ARE YOUR PERSONAL GOALS.OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?
1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN ________________

AND WHY _______________________________________________________________

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?: ________________________________________________

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? ________________

CURRENT MEDICATIONS: _______________________________________________________________________

ALLERGIES: Medication Reaction Other Reaction _______________________________________________________________________

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction ___________________

Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction ___________________

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ ANEMIA ☐ DIABETES ☐ controlled ☐ uncontrolled ☐ RESPIRATORY PROBLEMS
☐ ARTHRITIS ☐ DEPRESSION ☐ ASTHMA ☐ controlled ☐ uncontrolled
☐ CANCER ☐ DIZZINESS/FAINTING ☐ COPD ☐ controlled ☐ uncontrolled
☐ CARDIOVASCULAR PROBLEMS ☐ FRACTURES ☐ Other
☐ HOLTER MONITOR - currently wearing? ☐ HEADACHES ☐ SEIZURES ☐ controlled ☐ uncontrolled
☐ PACEMAKER ☐ HEPATITIS/HIV ☐ THYROID PROBLEMS
☐ HIGH BLOOD PRESSURE ☐ controlled ☐ uncontrolled ☐ KIDNEY PROBLEMS ☐ BLOOD THINNERS (Anticoagulants)
☐ LOW BLOOD PRESSURE ☐ MRSA (Methicillin Resistant Staphylococcus Aureus)
☐ CURRENTLY PREGNANT ☐ OSTEOPOROSIS

If checked any above, explain: _______________________________________________________________________

☐ ANY OTHER MEDICAL PROBLEMS: _______________________________________________________________________

SIGNATURE OF PATIENT: ___________________________ REVIEWED BY Therapist: ______________________ Date ___________

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