PAST MEDICAL HISTORY

Name:____ Date:___________________________

Diagnosis or reason for coming to therapy:____

Family or Primary Care Physician:____

To assist in providing you the best care possible, please complete the following past medical history questionnaire to the best of your ability. All information will be kept confidential.

Have you or do you have any of the following?

	YES	NO		YES	NO
Angina	__	__	Pulmonary/Breathing Problems	__	__
Balance Disorder	__	__	Rheumatoid Arthritis	__	__
Cancer	__	__	OsteoArthritis	__	__
Cardiac Pacemaker	__	__	Joint Replacements	__	__
Diabetes	__	__	Stroke (CVA)	__	__
Gout	__	__	Orthopedic Surgeries	__	__
Heart Attack	__	__	Other Surgeries	__	__
Hypertension	__	__	Fractures	__	__
Kidney Dysfunction	__	__	Metal Implants	__	__
Organ Transplants	__	__	Osteoporosis	__	__

Please provide further information to any of the above questions you answered as YES:______________________

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Are you presently taking any MEDICATIONS ?_______________ If yes, what are they ?_____________________

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Are you, or is there a chance you may be, pregnant ?_____________________________

In case of an emergency, who should we contact? _____________________ Relationship to you:_______________

Phone #:___________________

The above information that I have provided to Advanced Hand Rehabilitation is, to the best of my knowledge, true and correct.

Signature:____ Date:___________________________

Patient or Guardian