TUCSON ORTHOPAEDIC INSTITUTE

MRN:____________________ Therapist:______

Physical and Occupational Therapy Medical History

Name: ____

Height: ______________ Weight: ________________ **Date of Birth:** ____________________

How did your problem begin? Onset date of problem: ______________

□ Motor vehicle accident: Have you filed an Auto accident claim for this injury? Yes/No

□ Sports/training □ Chronic illness/condition □ Post surgical □ Work-related injury □ Unknown/Other

Circle the amount of pain you have had in the last 24 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain Requiring ER

		Yes	**No**
1) Received previous treatment for current condition?			
If so, describe: ______________________		□	□
2) Do you have a pacemaker?		□	□
3) Do you have metal implants?		□	□
Where? ______________________			
4) Have you had or do you currently have cancer?		□	□
Type? ______________________			
5) Are you doing any regular exercise?		□	□
6) Current or previous smoker/tobacco user?		□	□
If current, how many packs/day? ____________			
7) Have you fallen in the past year?		□	□
If yes, were you injured?		□	□
8) Are you currently enrolled in Home Health of SNF?		□	□
9) If female, are you currently pregnant?	N/A □	□	□

List any allergies that you may come in contact with during therapy:

□ Latex □ Tape sensitivity □ Cortisone □ Other:______________________

Please list or attach meds (including vitamins) you are taking: if different from list given to TOI MD

Medication	Dosage	Frequency	Injected/Oral/Topical	

List any surgeries, conditions, or injuries for which you have been hospitalized, or attach list

Surgery/Reason for Hospitalization	Approximate Date

Have you ever been diagnosed as having any of the following conditions? Mark

□ Anemia □ Arthritis □ Asthma □ Cancer □ Chemical Dependency

□ Diabetes □ Emphysema □ Epilepsy/Seizures □ Fibromyalgia □ Heart Attack

□ Heart Disease □ Hepatitis □ High Blood Pressure □ Lupus □ Stroke

□ Tuberculosis □ Kidney Disease □ Liver Disease □ Osteoporosis □ Infection (if current)

□ Multiple Sclerosis □ Thyroid Problem □ Soft Tissue Infection/Rash □ Depression

□ Temporo-Mandibular Joint Problems □ Other: ______________________________

Patient Signature: ______________________________ **Date:** ______________

Therapist Signature: ______________________________ Date: ______________