Memorial Hospital
One Ingalls Drive, Harvey, Illinois 60426 (708) 333-2300

# Patient Medical/Surgical History

Department of Therapy Services
(Physical, Speech and Occupational Therapy)

*P T 0 3 7 6*

## MEDICAL/SURGICAL HISTORY

Please check if you have or ever had:
(Please check all that apply)

- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Broken Bones
- ☐ Cancer
  Type:____________________
- ☐ Cardiac Problems
- ☐ Circulation Problem
- ☐ Depression
- ☐ Diabetes
- ☐ Growth Problems
- ☐ Head Injury
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
  Dialysis ☐ Yes ☐ No
- ☐ Lung Problems
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Repeated Infections
- ☐ Seizure/Epilepsy
- ☐ Skin Disease
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers/Stomach Problems
- ☐ Other:________________

Within the past year, have you had any of the following symptoms? (Please check all that apply)

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of Breath
- ☐ Dizziness or Blackouts
- ☐ Coordination Problems
- ☐ Weakness in Arms or Legs
- ☐ Loss of Balance
- ☐ Difficulty Walking
- ☐ Joint Pain/Swelling
- ☐ Pain at Night
- ☐ Gynecological/ Obstetrical Difficulties
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Nausea/Vomiting
- ☐ Difficulty Swallowing
- ☐ Bowel Problems
- ☐ Weight Loss/Gain
- ☐ Urinary Problems
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Prostate Disease
- ☐ Pregnant (or think you may be)
- ☐ Other:____________________________________________

Do you smoke? ☐ Yes ☐ No
If yes, how many packs/day?__________________
For how long?________________________________

HAVE YOU EVER HAD SURGERY? ☐ Yes ☐ No
If yes, please describe and include dates:

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

## CURRENT CONDITION(S)/ CHIEF COMPLAINT(S)

Describe the problem to which you seek therapy:

_______________________________________________
_______________________________________________
_______________________________________________

When did the problem(s) begin? ______________________
Please describe what happened:

_______________________________________________
_______________________________________________
_______________________________________________

Have you ever had the problem(s) before? ☐ Yes ☐ No
If yes, what did you do for the problem(s):

_______________________________________________
_______________________________________________
_______________________________________________

Did the problem(s) get better? ☐ Yes ☐ No
How long did the problem(s) last? ____________________

What makes the problem(s) better?

_______________________________________________
_______________________________________________

What makes the problem(s) worse?

_______________________________________________
_______________________________________________

What are your goals for therapy?

_______________________________________________
_______________________________________________

## MEDICATIONS (Type and Amount)

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Have you taken any medications previously for the condition for which you are seeing the therapist? ☐ Yes ☐ No
If yes, please list:________________________________

Allergies:

_______________________________________________
_______________________________________________
_______________________________________________

Patient Signature:______________________________________________ Date:____________________