## Medicial History/ Evaluation

Name: ____________________________________________ Date: ______________________

Referring Physician: _________________________________ Date of Injury/Onset: __________

Date of first doctor visit for this injury: ________________ Last day worked due to this injury:____________

Current work status: ___________________ Is an attorney involved in this case: YES NO

Have you had any other Diagnostic or Rehabilitative Services for this injury/episode: YES NO

If so, what type: (i.e., x-rays, MRI, EMG,)__________________________ When? ___________________

Have you had surgery for this injury? YES NO Type of Surgery/Date: ____________________

List other Surgeries: ___________________________________________________________________

_____________________________________________________________________________________

Do you now have or have you ever had any of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Asthma, Bronchitis or Emphysema | ___ | ___ | Weakness | ___ | ___ |
| Shortness of Breath/Chest Pain | ___ | ___ | If so, where: ___________________________ | | |
| Coronary Heart Disease or Angina | ___ | ___ | Numbness or Tingling | ___ | ___ |
| Do you have a pacemaker | ___ | ___ | Dizziness or Faintness | ___ | ___ |
| High Blood Pressure | ___ | ___ | Hernia | ___ | ___ |
| Heart Attack/Surgery | ___ | ___ | Varicose Veins | ___ | ___ |
| Stroke/TIA | ___ | ___ | Allergies | ___ | ___ |
| Blood Clot/Emboli | ___ | ___ | Joint Replacement | ___ | ___ |
| Epilepsy/Seizures | ___ | ___ | Neck Injury/Surgery | ___ | ___ |
| Thyroid Trouble/Goiter | ___ | ___ | Shoulder Injury/Surgery | ___ | ___ |
| Anemia | ___ | ___ | Elbow Injury/Surgery | ___ | ___ |
| Infectious Disease | ___ | ___ | Back Injury/Surgery | ___ | ___ |
| Diabetes | ___ | ___ | Knee Injury/Surgery | ___ | ___ |
| Cancer or Chemotherapy/Radiation | ___ | ___ | Leg/Ankle/Foot Injury/Surgery | ___ | ___ |
| Arthritis/Swollen Joints | ___ | ___ | Any Pins or Metal Implants | ___ | ___ |
| Osteoporosis | ___ | ___ | Are you pregnant? | ___ | ___ |
| Gout | ___ | ___ | Sleeping Problems/Difficulties | ___ | ___ |
| Emotional/Psychological problems | ___ | ___ | Bowel or Bladder problems | ___ | ___ |
| Do you smoke? _______ How much? ___________ | | | Severe or Frequent Headaches | ___ | ___ |
| Alcohol Consumption? ______ How much? __________ | | | Vision or Hearing Difficulties | ___ | ___ |

List any other information that would assist us in your care: ______________________________________

_____________________________________________________________________________________

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