

## **Spartanburg Regional**

### **PATIENT MEDICAL HISTORY**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF NEXT DOCTOR'S APPT: \_\_\_\_\_

ARE YOU PRESENTLY WORKING?  YES  NO; IF YES  LIGHT/MODERATE DUTY  REGULAR DUTY

ARE YOU  RIGHT OR  LEFTHANDED?

WHICH AREA IS THE PROBLEM?  HEADACHES  TMJ  NECK  UPPER BACK  LOW BACK  
 ARM (  (R) OR  (L) )  SHOULDER  ELBOW  WRIST  HAND  FINGER  HIP  KNEE  ANKLE  
 LEG  FOOT  TOE OTHER: \_\_\_\_\_

HOW DID THIS PROBLEM BEGIN?

LIFTING  TWISTING  FALLING  CRUSHING  MOTOR VEHICLE ACCIDENT  UNKNOWN  OTHER

DATE OF INJURY OR WHEN PROBLEM FIRST OCCURRED: \_\_\_\_\_

WAS THE ONSET:  GRADUAL OR  SUDDEN?

IF YOU HAVE HAD THIS PROBLEM FOR A LONG TIME WHEN DID IT **RECENTLY** BECOME WORSE? \_\_\_\_\_

ARE YOU CURRENTLY BEING SEEN BY ANY OF THE FOLLOWING?

MEDICAL DOCTOR  SPEECH THERAPIST  DENTIST  PSYCHIATRIST/PSYCHOLOGIST  
 PHYSICAL/OCCUPATIONAL THERAPIST  OSTEOPATH  CHIROPRACTOR

IF YOU HAVE BEEN SEEN BY ANY OF THE ABOVE DURING THE PAST SIX MONTHS, PLEASE DESCRIBE FOR WHAT REASON: \_\_\_\_\_

HAVE YOU BEEN HOSPITALIZED FOR THIS PROBLEM?  YES  NO IF YES GIVE DATES: \_\_\_\_\_

HAVE YOU HAD ANY OF THE FOLLOWING TESTS FOR THIS CONDITION? IF YES GIVE DATES: \_\_\_\_\_

X-RAYS \_\_\_\_\_ MRI \_\_\_\_\_ CAT SCAN \_\_\_\_\_ BONE SCAN \_\_\_\_\_ OTHER \_\_\_\_\_ NONE \_\_\_\_\_

PLEASE LIST ANY SURGERIES (IN/OUT PATIENT) AND ANY REASOSN FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	REASON	DATE	REASON	DATE	REASON
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING?

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> SEIZURES	<input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/> ELEVATED CHOLESTEROL
<input type="checkbox"/> <input type="checkbox"/> CANCER	<input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS	<input type="checkbox"/> <input type="checkbox"/> DIABETES
<input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> <input type="checkbox"/> GI PROBLEMS	<input type="checkbox"/> <input type="checkbox"/> DO YOU SMOKE
<input type="checkbox"/> <input type="checkbox"/> HEPATITIS	<input type="checkbox"/> <input type="checkbox"/> RHEUMATOID ARTHRITIS	<input type="checkbox"/> <input type="checkbox"/> DO YOU LEAD A SEDENTARY LIFESTYLE
<input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> <input type="checkbox"/> OTHER ARTHRITIC CONDITIONS	<input type="checkbox"/> <input type="checkbox"/> HISTORY OF HEART DISEASE OR
<input type="checkbox"/> <input type="checkbox"/> DEPRESSION	<input type="checkbox"/> <input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/> <input type="checkbox"/> SURGERY (Yourself or Family)

OTHER: \_\_\_\_\_ ALLERGIES-DRUGS/X-RAY DYES: \_\_\_\_\_

HAVE YOU EVER HAD A FRACTURE OR DISLOCATION?  YES  NO ARE YOU PREGNANT?  YES  NO

IF YES, WHICH BODY PART: \_\_\_\_\_ DATE: \_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING METALS OR PLASTICS IN YOUR BODY?

RODS  PINS  PLATES  STAPLES  ARTIFICIAL JOINTS  METAL FROM GUNSHOT WOUND  NONE

LOCATION: \_\_\_\_\_

LIST ANY MEDICATIONS OR RECENT INJECTIONS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

IF OTHER THAN PATIENT, RELATIONSHIP: \_\_\_\_\_

REVIEWED BY THERAPIST: \_\_\_\_\_

DATE: \_\_\_\_\_