TRAHC

Tuscaloosa
Rehabilitation
and
Hand
Center

Patient Medical History Questionnaire

Name: _____ Referring Doctor:_____
Family Doctor:_____ Date of First MD visit for Injury:_____
Last Date Worked Due to Injury:_____ Date Returned to Work after Injury:_____
Next MD Appointment Date: _____Attorney Involvement? **Yes** **No**
Have you had Surgery for this Injury? **Yes** **No** Number of Surgeries: 1 2 3 4 ___
Type of Surgery: _____ Surgery Performed at: **Hospital**__ **Surgery Center**__
Are you currently taking Prescription or Non-Prescription Medication? **Yes** **No**
Anti-Inflammatories __ **Muscle Relaxers** __ **Pain Meds** ___
List any Other Medications: _____
_____
Allergic to any Medications? **Yes** **No** List Meds: _____
Have you had any of the following treatment for this Injury/Problem?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	Myelogram	___	___
Massage Ther.	___	___	MRI	___	___
Occupational Ther.	___	___	X-Rays	___	___
Physical Ther.	___	___	Neurologist	___	___
Emergency Room	___	___	Podiatrist	___	___
General Pract.	___	___	Orthopedist	___	___

Other: _____
Do you **NOW** have or Have you **EVER** had **ANY** of the following?

	YES	NO		YES	NO
Shortness of Breath/Chest Pain:	___	___	Severe Headaches	___	___
Heart Disease or Angina	___	___	Dizziness/Fainting	___	___
Do You have a Pacemaker?	___	___	Vision/Hearing Probs.	___	___
Heart Attack/Hurt Surgery?	___	___	Numbness/Tingling	___	___
Blood Clots/Emboli	___	___	Bowel/Bladder Probs	___	___
Stroke/TIA	___	___	Weakness	___	___
Seizures/Epilepsy	___	___	Weight Loss	___	___
Infectious Disease	___	___	Hernia	___	___
Diabetes	___	___	Vericose Veins	___	___
Cancer/Chemo/Radiation	___	___	Allergies	___	___
Arthritis/Gout/Osteoporosis-**cir**	___	___	Joint Replacement	___	___
Sleeping Problems	___	___	Neck Injury/Surgery	___	___
Emotional/Psych Problems	___	___	Shldr Injury/Surgery	___	___
Any Pins or Metal Implants?	___	___	Elbow/Hand Surgery	___	___
Are You Pregnant?	___	___	Back Injury/Surgery	___	___
Do You Use Tobacco?	___	___	Knee Injury/Surgery	___	___

Are You aware of Your Diagnosis? **Yes** **No** Based on your awareness of your diagnosis, what are your rehab goals?_____
List any other information that would assist us in your care:_____

Patient / Guardian Signature: _____ **Date:** _____