Previous Medical History Form

MHC1213

Name:_____ Birthdate: _____

Phone #: _____ Email: _____ Age: _____

Height: _____ Weight: _____ Sex: M F Hand Dominance: L/R/ Ambidextrous

Current Diagnosis:_____

Referring Physician: _____ Primary Language: _____

How do you prefer to learn: (Please circle one) Visual or Auditory

Medical History: (Please check all that apply)

__Heart Disease	__Diabetes	__High Blood Pressure	__Pacemaker/Aneurysm clips
__Dizziness/Fainting	__Epilepsy/Seizures	__HIV/AIDS	__Arthritis
__Hearing Impaired	__Visual Impaired	__Stroke	__Asthma/Shortness of Breath
__Latex Allergy	__Osteoporosis	__Hepatitis/Liver problems	__Hives/Skin rash
__Gout	__Anemia/Blood disorders	__Ulcers	__Polio
__Joint Replacements	__Cancer- Please explain: _____		
__Tuberculosis			

Do you consume alcohol: ☐ Yes ☐ No If so, how much (how many drinks per week)_____

Do you smoke: ☐ Yes ☐ No If so, how many packs per day and are you willing to cut down to increase healing rate for your condition? _____

Do you consume caffeine (coffee, tea, soft drinks)? If so, how many per day?_____

Are you allergic to anything?_____

If you are female, is there any possibility that you are pregnant? ☐ Yes ☐ No

How did your injury occur and when (or how long have you been having symptoms) and do you know why? _____

_____

Have you had any prior/previous diagnostic test for this condition you are being seen for today? (Please circle if applicable): X-ray, MRI, CT scan, Arthrogram, Nerve conduction tests, EMG,

ADHERE PATIENT LABEL WITHIN THIS AREA

Have you had any prior/previous treatments for this condition you are being treated for today? ☐ Yes ☐ No

Injections: (If so, how many and where) _____

Chiropractic: (If so, when and how many treatments) _____

Therapy: (If so, when and how many treatments) _____

What kind of outcome did you have with these treatments: ☐ Significant improvements,

☐ Marginal improvements, ☐ Short term Symptomatic relief, ☐ No improvement, or Worsening

Is your pain? (Please circle one) Constant, Intermittent, Brief, Momentary, Periodic, Transient

Please rate your pain using a 0-10 scale: (0= No pain, 10= worse pain you can imagine)

Worse pain since onset:_____ Worse pain in the past 4 weeks:_____

Least amount of pain since onset:_____ Today's pain:_____

Does the pain wake you up at night: ☐ Yes ☐ No

What position helps you sleep? _____

What makes your pain better? _____

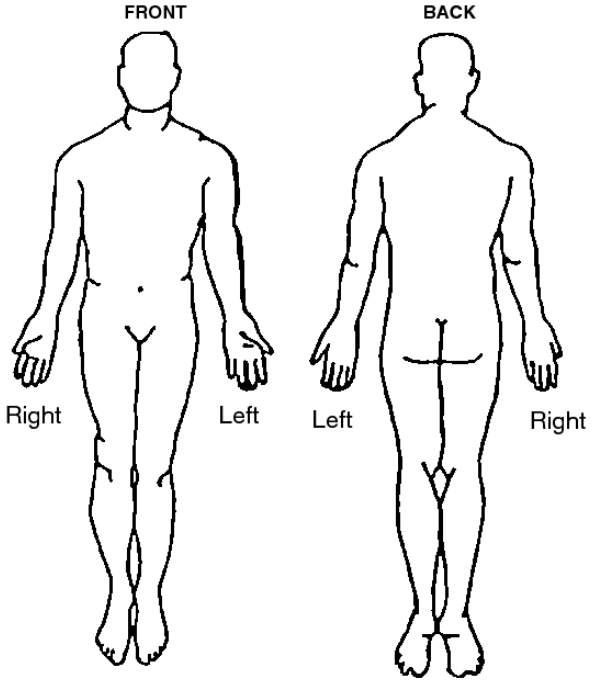
What makes you pain worse? _____

Please use the key to indicate the location & nature of your pain on the diagram below

NCN PAIN DRAWING GRID ASSESSMENT

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
////	B B B	X X X X	= = =	Z Z Z	O O O O
///	B B B	X X	= = =	Z Z Z	O O O O

Percentage of pain in back _____ Percentage of pain in legs _____



NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE PAIN

(CIRCLE YOUR PAIN ESTIMATE)

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist SUGAR LAND HOSPITAL

Previous Medical History Form

MHC1212

SIGNIFICANT MEDICAL DIAGNOSIS & CONDITIONS		
DATE/TIME	LIST	COMMENTS

SIGNIFICANT OPERATIVE & INVASIVE PROCEDURES			
DATE/TIME	LIST	DATE OF PROCEDURE	COMMENTS

MEDICATIONS (Prescription, Over-the-Counter, Herbal, Vitamins)					
DATE/TIME	DRUG NAME	ROUTE	DOSAGE	FREQUENCY	INDICATION

ADVERSE OR ALLERGIC DRUG REACTIONS		
DATE/TIME	LIST	COMMENTS

* INITIATED FOR THE PATIENT BY THE THIRD VISIT AND MAINTAINED THEREAFTER.
* EXERCISE FLOWSHEETS WILL BE UTILIZED TO DOCUMENT WHETHER OR NOT CHANGES HAVE OCCURRED.

Therapist: _____ Date/Time: _____

ADHERE PATIENT LABEL WITHIN THIS AREA

HOUSTON Methodist SUGAR LAND HOSPITAL

OUTPATIENT PT/OT SUMMARY LIST

DATE	TIME	COMMENTS

ADHERE
PATIENT LABEL
WITHIN THIS
AREA

HOUSTON Methodist SUGAR LAND HOSPITAL

OUTPATIENT PT/OT
SUMMARY LIST