

SportWorks Rehabilitation Center

275 WEST BASSET ROAD, SUITE 1, SHELBYVILLE, INDIANA 46176 • 317-392-5855 / FAX 317-398-1871

PATIENT MEDICAL HISTORY

Brief Description of the Problem:		If in pain, please rate on scale from 0=no pain, 10=worst pain. 1 2 3 4 5 6 7 8 9 10	
Date Problem Started/Date of Injury:		Where did this happen? <input type="checkbox"/> Automobile <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	
Occupation/School:	Are you off work/out of school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Last Worked:	Age:
Referred By:	Family Physician:	Height: Feet inches	Weight:
Drug Allergies: Allergic to: <input type="checkbox"/> None <input type="checkbox"/> Adhesives <input type="checkbox"/> Contrast Dye <input type="checkbox"/> Cortisone <input type="checkbox"/> Latex <input type="checkbox"/> Seafood <input type="checkbox"/> Other			
<input type="checkbox"/> Current Medications , including herbs and/or supplements: List drug name and dosage on lines below. <input type="checkbox"/> I do not take prescription medicines.			
List All Previous Surgeries below. Indicate the type of surgery and year. <input type="checkbox"/> I have never had surgery.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is there a chance you are pregnant?		Assistive Devices: <input type="checkbox"/> Yes <input type="checkbox"/> No Are you able to walk? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use a cane or walker?	
<input type="checkbox"/> Right <input type="checkbox"/> Left Dominant Hand			
General Health <input type="checkbox"/> Yes <input type="checkbox"/> No Antibiotic Resistance Illnesses (MRSA/VRE) <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Chills <input type="checkbox"/> Yes <input type="checkbox"/> No Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Weight Loss/Appetite Change Skin <input type="checkbox"/> Yes <input type="checkbox"/> No Rashes/Lesion <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers/Scar Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Double Vision/Blurring <input type="checkbox"/> Yes <input type="checkbox"/> No Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Ears, Nose, Throat, and Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Deafness <input type="checkbox"/> Yes <input type="checkbox"/> No Hoarseness <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in Ears <input type="checkbox"/> Yes <input type="checkbox"/> No Sinusitis <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No Airway Abnormalities <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma, Wheezing, Bronchitis, Emphysema, TB, or other lung problems, COPD <input type="checkbox"/> Yes <input type="checkbox"/> No Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Cough Up Blood <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath After Walking One City Block <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Apnea		Cardiovascular <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking Coumadin or other blood thinner? <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain How often? _____ Daily _____ Weekly _____ Monthly <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease/Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular Heartbeat, Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker, Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No Peripheral Vascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever, Heart Murmur Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Heartburn, Hiatal Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No GI Bleed (gastrointestinal) <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis, Cirrhosis, Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers Bladder and Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No Hesitancy <input type="checkbox"/> Yes <input type="checkbox"/> No Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Failure, Dialysis, Urinary Problems, Kidney Disease Bones, Muscles, and Joints <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis, Stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Sprains/Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No Total Hip/Knee Replacement R L	
Neurological/ Psychological <input type="checkbox"/> Yes <input type="checkbox"/> No Balance/Dizziness, Falls <input type="checkbox"/> Yes <input type="checkbox"/> No Brain Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions, Seizures, Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Memory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine, Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness/Tingling Arms/Legs <input type="checkbox"/> Yes <input type="checkbox"/> No Speech or Swallowing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Weakness Blood Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia or Sickle Cell Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Clots <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Positive, AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No Lymph Node Pain/Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged Bleeding After Minor Cut or Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose Veins Allergic/Immunologic <input type="checkbox"/> Yes <input type="checkbox"/> No Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Unusual Reaction to Anesthesia By You or By a Family Member Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes, Onset Age: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Growth Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medical Problem: _____			
Has a physician ever warned you against exercise?		Have you ever been placed on any medical restrictions?	
Social History: <input type="checkbox"/> Yes <input type="checkbox"/> No Do you smoke? Pack(s)/Day _____ Number of Years _____ Family History: <input type="checkbox"/> Yes <input type="checkbox"/> No Is your mother living? <input type="checkbox"/> Yes <input type="checkbox"/> No Is your father Living?		<input type="checkbox"/> Yes <input type="checkbox"/> No Do you average 3 or more alcoholic beverages per day? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have children? Children's Names: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No How many brothers do you have? <input type="checkbox"/> Yes <input type="checkbox"/> No Are all brothers alive?		<input type="checkbox"/> Yes <input type="checkbox"/> No How many sisters do you have? <input type="checkbox"/> Yes <input type="checkbox"/> No Are all sisters alive?	
Please indicate which of your blood relatives (M=Mother, F=Father, S=Sister, B=Brother) have a history of the following health problems :			
<input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeds easily <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraine <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> None of these problems in my family.

Parent or Legal Guardian Signature

Date