IMPACT
Rehab & Wellness

MEDICAL HISTORY

MEDICAL QUESTIONNAIRE

Patient's Name: _____ DOB: _____
Last First Middle

Age: _____ Weight: _____ Height: _____ ☐ Right Handed ☐ Left Handed

Have You Received Home Health Care In The Last 90 Days ☐ Yes ☐ No

Date When Your Condition Started: _____ Did You Have Surgery ☐ Yes ☐ No Date Of Surgery: _____

Have You Had This Problem Before ☐ Yes ☐ No

Please Indicate Your Present Pain (0=No Pain / 10=Worst Pain Imaginable/ER)
0 1 2 3 4 5 6 7 8 9 10

Please Indicate Your Pain At Its Worst In The Past 2 Weeks (0=No Pain / 10=Worst Pain Imaginable/ER)
0 1 2 3 4 5 6 7 8 9 10

Which Diagnostic Tests You Have Had For This Condition:
☐ X-Ray ☐ MRI ☐ CAT Scan ☐ EMG/Nerve Conduction ☐ Bone Scan ☐ Blood Test ☐ Ultra Sound/Doppler

What Treatments You Have Received For This Condition:
☐ Rest ☐ Exercise ☐ Physical Therapy ☐ Chiropractic ☐ Massage Therapy ☐ Medications ☐ Heat Or Ice

MEDICAL HISTORY (Check Any That Apply)

☐ Angina/Chest Pain	☐ Cancer	☐ Hearing Problems	☐ Osteoporosis
☐ Asthma	☐ Depression	☐ Heart Disease	☐ Pacemaker/Nitroglycerin
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Poor Circulation/Raynaud's
☐ Blackouts	☐ Diverticulitis	☐ High Blood Pressure	☐ Polio
☐ Blindness	☐ Ear Infections	☐ High Cholesterol	☐ Seizures
☐ Blood Clot	☐ Endometriosis	☐ Hypoglycemia	☐ Stroke
☐ Bowel Or Bladder Problems	☐ Fibroids	☐ Menopause	☐ Tuberculosis
☐ Carpal Tunnel Syndrome	☐ Fibromyalgia	☐ Migraine Headaches	☐ Traumatic Injury/MVA
☐ Chest/Abdominal Surgery	☐ Fractures	☐ Major Spinal Injury	☐ Other: _____
☐ Coronary Artery Disease	☐ Frequent Falls	☐ MRSA	_____

Are You Pregnant? ☐ Yes ☐ No Do You Smoke? ☐ Yes ☐ No If Yes, How Much: _____ How Long: _____

MEDICATIONS/ALLERGIES/SURGERIES

List Current Medications: _____
_____

List Current Allergies: _____
_____

List All Surgeries: _____
_____

_____ _____
Signature Date