



**BERGER HEALTH SYSTEM**

Physical Medicine & Rehabilitation

# Medical History Form

Patient: \_\_\_\_\_

Are you on any medications? Please list: \_\_\_\_\_

Medication List Supplied

Have you ever had any of the following?  EMG  CT Scan  MYELOGRAM  MRI  XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowels / Bladder Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver / Gallbladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List:		
Other: (Continue Below if needed)		

Ringling in your ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List with dates:		

Please check all that may apply. My pain is worse:

In the morning  During the day  At Night

Constant  With Activity  During rest

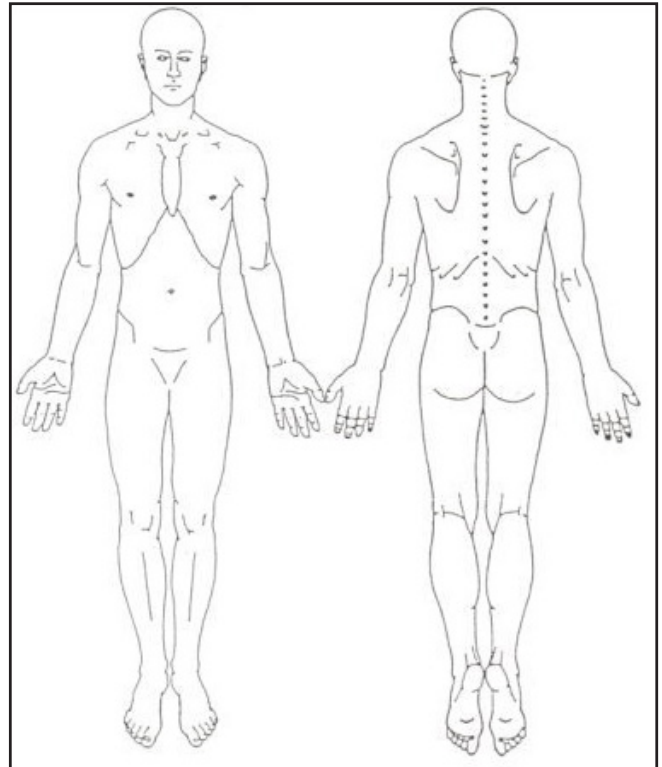
With 0 being no pain and 10 being unbearable pain requiring hospitalization:

Please rate your pain at its best \_\_\_\_\_ at its worst \_\_\_\_\_

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

KEY

- +++ Radiating Pain
- XXX Spasm
- ZZZ Tenderness
- //// Numbness / Tingling
- 000 Ache / Pain



Signature of Patient or Guardian (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient:  Self  Guardian  Other

Clinician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_