



STONY BROOK MEDICINE HAND THERAPY MEDICAL HISTORY FORM

Name: _____ Daytime phone #: _____

Occupation: _____

Hobbies: _____

· Date of injury / accident / disease _____ · Date of surgery _____ · Right / Left hand dominant

· Describe your symptoms and the reason for this appointment:

· When are you scheduled to return to your referring physician? _____

· Have you had PT/OT or chiropractor elsewhere for your current condition? _____

Pain Management:

Please indicate your pain at rest _____ and with activity _____: 0-10 (0 = NO PAIN; 10 = WORST PAIN EVER)

Past Medical History:

Have you ever had any of the following conditions? *Check all that apply.*

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis (Rheumatoid or Osteoarthritis) _____ |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Lymphedema _____ |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Fainting/dizziness _____ |
| <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Vision problems _____ |
| <input type="checkbox"/> Pacemaker / Defibrillator | <input type="checkbox"/> Frequent or severe headaches _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> HIV /AIDS _____ |
| <input type="checkbox"/> Lupus or other Rheumatic disorder _____ | <input type="checkbox"/> Other: _____ |

Do you have a history of fractures? YES / NO Where? _____

Do you have any metal implants? YES / NO Where? _____

Do you smoke -YES / NO? Past / Present? Number of years? _____ Number of packs per day? _____

Diagnostic Tests: Please check any tests or procedures that have been done for your **current** condition.

- X-rays MRI CT scan Bone scan EMG Blood work Bone density Ultrasound

Medications:

Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking: _____

Surgeries: Please list all surgeries including dates: _____

Functional difficulties: *Please CIRCLE those which you have difficulty with.*

- DOOR KNOBS STARTING A CAR BUTTONS ZIPPERS SHOELACES BELT BUCKLE
- CAR DOORS HAIR DRYER SHAVING MEAL PREPARATION FEEDING SELF DRIVING
- BATHING HANDLING MONEY OPENING JARS & BOTTLES WRITING LIFTING

Please sign acknowledging review of this information:

Patient signature: _____ Therapist signature: _____ Date: _____ Time: _____