PMG Physiatry
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Physical Medicine and Rehabilitation
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541-732-8360

Name _____
Birth date_____ Age_____
Contact Phone _____
Primary Doctor _____
Referring Doctor _____
Caregiver's Name _____

Date: _____

Health History Form

Reason for coming to the office today:
_____

When I leave the office today, I would like to have accomplished:
_____
_____
_____

Have you had prior treatment/therapy for this problem? Yes No Explain:
_____
_____

What, if anything, helped?
_____

Have you seen other physicians for this problem? Yes No
*Whom*_____ _____
_____ _____

Explain how the problem you are being seen for is affecting your daily life?
_____
_____
_____

What are you limited in doing currently that you would like to do again?
_____
_____
_____

Past Surgical History:

Date	Operation	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

□ No past surgical procedures

Past History:

- ☐ Migraine Headaches
- ☐ Traumatic Brain Injury
- ☐ Sports Concussion
- ☐ Stroke/TIA
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Vasculitis
- ☐ Prostate Hyperplasia (BPH)
- ☐ Kidney Disease
- ☐ Psoriasis
- ☐ Other _____

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ High Cholesterol
- ☐ Lymphedema
- ☐ Urinary Incontinence
- ☐ Pressure Ulcers
- ☐ Osteoporosis
- ☐ Osteoarthritis
_____

- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Tuberculosis
- ☐ GERD/Reflux/Indigestion
- ☐ Bowel incontinence
- ☐ Constipation
- ☐ Cancer-Type: _____
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus Erythematous
- ☐ Down's syndrome
_____

Review of Systems: Do you currently have any of the following:

GENERAL

	YES	NO
Recent Fever	☐	☐
Weight loss	☐	☐
Night Sweats	☐	☐
Loss of energy	☐	☐
Change in lymph nodes	☐	☐
Snoring	☐	☐
Trouble sleeping	☐	☐

BLOOD

	YES	NO
Easy Bruising	☐	☐
Excessive Bleeding	☐	☐
Transfusions	☐	☐

CARDIOVASCULAR

	YES	NO
Palpitations	☐	☐
Heart Murmur	☐	☐
Chest Pain	☐	☐
Varicose Veins	☐	☐

ENDOCRINE

	YES	NO
Thyroid Disorder	☐	☐
Goiter	☐	☐

EARS/NOSE/THROAT

	YES	NO
Ringing	☐	☐
Difficulty Hearing	☐	☐
Nasal Congestion	☐	☐
Sinus Pain	☐	☐
Sore Throat	☐	☐
Difficulty Swallowing	☐	☐

DIGESTIVE

	YES	NO
Poor appetite	☐	☐
Gas or heartburn	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Bowel Incontinence	☐	☐
Rectal Bleeding	☐	☐
Hernia	☐	☐

GENITOURINARY

	YES	NO
Burning w/ urination	☐	☐
Bloody Urine	☐	☐
Incontinence	☐	☐
Infections	☐	☐
Difficulty w/ urination	☐	☐
Urination at night: # times_____		
Difficulty with erections	☐	☐

RESPIRATORY

	YES	NO
Pain when you breathe	☐	☐
Wheezing	☐	☐
Excessive sputum	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐

EYES

	YES	NO
Cataracts	☐	☐
Blind spots	☐	☐
Double vision	☐	☐
Last Eye Exam_____		

MUSCULOSKELETAL

	YES	NO
Arthritis	☐	☐
Fractures	☐	☐
Spasms	☐	☐
Neck pain	☐	☐
Back Pain	☐	☐
Arm Pain	☐	☐
Leg Pain	☐	☐
Pain with Sitting	☐	☐
Pain with Walking	☐	☐
Weakness	☐	☐

NEUROLOGICAL

	YES	NO
Stroke	☐	☐
Convulsions	☐	☐
Dizziness	☐	☐
Blackouts	☐	☐
Headaches	☐	☐
Numbness/Tingling in arms/legs	☐	☐

PSYCHOLOGICAL

	YES	NO
Depression	☐	☐
Anxiety	☐	☐
Poor Sleep	☐	☐
Hours of sleep without interruptions_____		

SKIN AND BREASTS

	YES	NO
Rashes	☐	☐
Changes in a mole	☐	☐
Infection	☐	☐
Discharge from nipple(s)	☐	☐
Breast Lumps	☐	☐

Family History:

□ Neuromuscular Disease	□ Alcoholism	□ Depression
□ Coronary Artery Disease	□ Diabetes	□ High Blood Pressure
□ Stroke	□ Heart Attack	□ Other_____
□ Osteoporosis	□ Cancer: Type_____	

Social History:

Tobacco Use □ Yes □ No Packs per day_____ How long? _____ Year Quit_____
Alcohol Use □ Yes □ No Drinks per day _____ □ Beer □ Wine □ Hard Liquor
Illicit Drug Use □ Yes □ No Type_____
(Cocaine, Meth, Marijuana, etc.)

City where you live	Occupation	Last day worked
_____	_____	_____

Live in: House Condo Apartment Trailer/RV Number of Stairs_____ Elevator: Yes No

How often do you exercise? None 1-2 week 2-4 week every day Type_____

Are you able to speak for yourself?	Yes	No
Are you able to perform your activities of daily living?	Yes	No
Are you currently involved in a legal case regarding today's problem?	Yes	No
Is this a worker's compensation case?	Yes	No
Have you or are you applying for disability?	Yes	No

Medications/Dose (*Current medications only, including over the counter medications)*:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies and Adverse Reactions:

Medication	Type of Reactions
_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

Thank you for your time in filling out this information.

Physician Signature: _____ Date: _____