Physical Medicine & Rehabilitation
1200 NE 48th Ave., #1100
Hillsboro, OR 97124

Date: ___/___/_____
Name: _____
DOB: ___/___/_____
Handedness: Right / Left

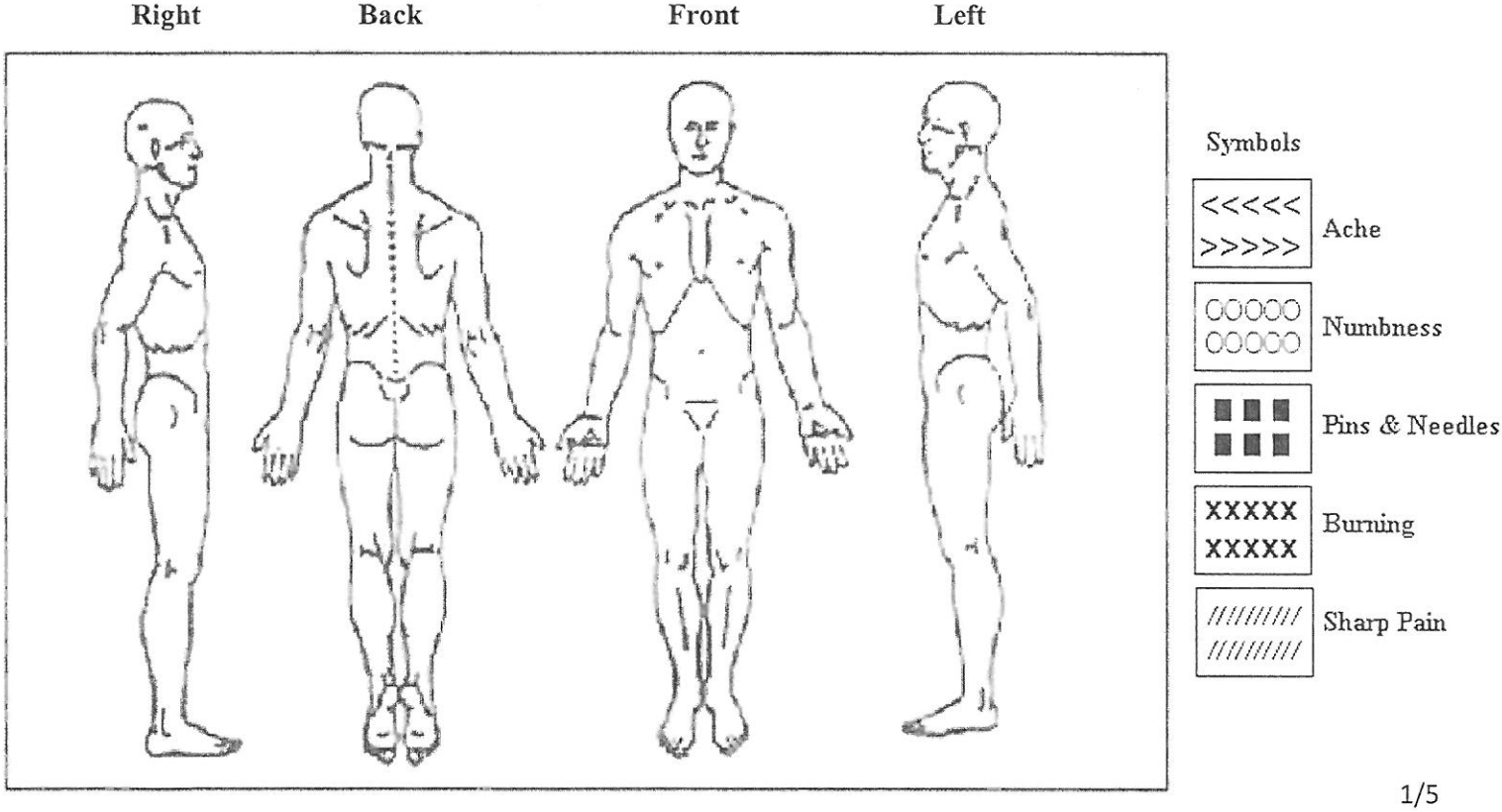
Patient Health History

Who is your Primary Care Physician? _____
Did your Primary Care Physician refer you to our office? Yes / No
If no, which doctor referred you? _____

History of Present Illness

What is bothering you? _____
When did the pain / problem start? _____
Where is your pain / problem located? _____
Quality of Pain (circle all that apply)
Aching Sharp Burning Stabbing Dull Throbbing Other: _____
Pain Severity 0-10 (0 = no pain to 10 = as if I've been hit by a car)
Average __ /10 Range: Best __ /10 Worst __ /10
If not pain, what is the problem severity? 0-10 (0 = does not bother me / 10 = bothers me a lot all of the time)
Average __ /10 Range: Best __ /10 Worst __ /10
What makes the pain / problem worse? _____
What makes the pain / problem better? _____
How long does it last? _____
What has been tried in the past? (circle all that apply)
What medications? _____ / Therapy / Injections / Acupuncture / Chiropractic

Type of Pain (Mark the areas on your body using the appropriate symbols to describe your symptoms)



Medical History (Circle medical condition and check the appropriate box below to describe whether the condition is current and ongoing or resolved. if the medical condition does not apply leave blank)

Current	Resolved	
		Alcoholism / Drug abuse
		Aortic Aneurysm
		Anemia
		Arthritis Type: Rheumatoid / Osteoarthritis / Don't Know / Other: _____
		Asthma
		Autoimmune Disorder, Type: _____
		Bleeding / Clotting Disorder, Type: _____
		Bronchitis
		Cancer, Type: _____ Year: _____ Treatment: Chemo / Surgery / Radiation / Other Treatment: _____
		Cataracts
		Colitis
		Coronary Artery Disease / Heart Disease / Heart Attack
		Depression
		Diabetes
		DVT (Deep Vein Thrombosis / Blood Clots)
		Emphysema / COPD
		Gastroesophageal Reflux Disease / Acid Reflux
		Gout
		Glaucoma
		Hepatitis, Type: _____
		Hernia, Type: _____
		Herpes
		High Blood Pressure
		High Cholesterol
		HIV/AIDS
		Irregular Heartbeat / Atrial Fibrillation
		Kidney Disease
		Liver Disease
		Leukemia
		Lung Disease
		Migraines / Headaches
		Miscarriage(s)
		Multiple Sclerosis
		Peripheral Vascular Disease
		Prostate Disorder
		Psychiatric Disorder, Type: _____
		Pulmonary Embolism (Blood Clot in the Lungs)
		Scarlet Fever
		Skin Disorder, Type: _____
		STD's, Type: _____
		Suicide Attempt(s)
		Stomach Ulcers
		Thyroid Disorder, Type: _____
		Tuberculosis

Past Surgeries (circle all that apply)

Appendix Removal
Arthroscopy Type: _____
Cesarean Section
Gallbladder Removal
Hernia Repair Type: _____
Hysterectomy
Implantable Device (Example: Spinal cord stimulator, Pacemaker, Defibrillator, etc) Type: _____
Joint Surgery or Replacement Type: _____
Lung Surgery Type: _____
Spine Surgery, Type or Level: _____
Other Surgeries _____

Family History (circle all that apply)

(First Degree Relatives ONLY - Mother, Father, Siblings - Please list in space provided below who had what disorder)

Alcohol Abuse _____
Arthritis _____
Autoimmune Disorder _____
Blood Clots (Type) _____
Cancer (Type) _____
Diabetes _____
Drug Use _____
Heart Disease _____
Hypertension _____
Other Family History _____

Social History / Marital Status (circle all that apply)

Married Never Married Divorced Widowed Remarried Separated
Are you working? Yes / No Your Occupation _____
Are you on disability? Yes / No If on disability for what reason? _____
Do you use tobacco? Yes / No If Yes: Smoke / Chew
How much Alcohol do you drink? (# of drinks per week: Beer, Wine & Liquor)
0 ____ 1-5 ____ 6-10 ____ 11-20 ____ Over 20 ____
Do you use recreational drugs? Yes / No If Yes: please list name and how often used? _____
Do you use medical marijuana? Yes / No

Medication Allergies & Reactions

Name / Reaction	Name / Reaction
_____	_____
_____	_____
_____	_____

Medications (Including Birth Control, Vitamins and Over the counter medications)

Name / Dose / Frequency (how many times per day)	Name / Dose / Frequency (how many times per day)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name and Location of Pharmacy you use to fill your prescriptions? _____

Review of Symptoms (circle all that apply)

Constitutional:
Fever / chills
Night sweats
Recent Weight gain / loss
Difficulty sleeping

Eyes:
Vision changes
Blurriness
Double vision

Ears / Nose / Mouth / Throat:
Difficulty hearing / hearing aids
Difficulty swallowing
Nasal congestion

Respiratory:
Difficulty Breathing
Cough
Sleep Apnea

Cardiovascular:
Chest Pain
Palpitations
Leg / arm swelling

GI:
Nausea / Vomiting
Diarrhea / Constipation
Loss of control / incontinence
Blood in stool

Genitourinary:
Erectile Dysfunction
Painful / difficult urination
Urinary incontinence
Bladder infection currently

Hematologic:
Frequent bruising

Immunological:
Chronic steroid

Musculoskeletal:
Neck pain
Back pain

Skin
Rash
Breakdown

Neurological:
Frequent headaches
Numbness
Tingling

Psychiatric:
Depression / Depressed Mood
Anxiety
Substance Abuse

Please list any other symptoms?

_____

_____

Goals of Evaluation and Treatment

(Example: a better understanding of what's going on, pain reduction, specific type of treatment - therapy, injection, medication, bracing)

_____

_____

_____

_____

_____

_____

_____

_____

Specific activities I would like to be able to resume or perform

(Example: I want to go back to work as a __?__, I want to run, I want to play with / hold / pick up my children or grandchildren, etc)

Questions I have for my Doctor