

LONG ISLAND UNIVERSITY CENTER FOR PHYSICAL REHABILITATION
Subjective Medical History

Patient Name: Last _____ First _____ Date _____

Date of Birth _____ Age _____ Date of Last Appointment w/ MD _____

Current Weight _____ Height _____ Date of Next Appointment w/ MD _____

Have you had/or ever been told you had:

General

- Weight loss/gain
- Loss of appetite
- Neck swelling/lumps
- Frequent headaches
- Daytime Fatigue
- Always hungry
- Lightheadedness
- Fever/chills
- Excessive sweating
- Insomnia
- Infectious Disease (such as tuberculosis, hepatitis, etc) _____

Metabolic/Endocrine

- Diabetes
- Hot/cold intolerance
- High cholesterol
- Gout

Allergies

- Food
- Medications
- Seasonal
- Bee Sting
- Hay Fever
- Latex

Skin

- Rash
- Itching
- Mole changes
- Tumors/cysts
- Unusual hair growth/loss
- Surgical scar(s)

Eyes

- Blurry vision
- Double vision
- Eye pain
- Blind spots
- Infections
- Cataracts
- Glaucoma
- Wear glasses/contacts

Mouth

- Teeth problems
- Jaw pain
- Bleeding gums
- Swelling on gum or jaws

Ears

- Hearing loss

- Infections

- Vertigo/dizziness

Nose/Throat

- Nose bleeds
- Sore throat
- Trouble swallowing

Musculoskeletal

- Weakness
- Painful feet
- Joint pain/swelling
- Back or shoulder pain
- Arthritis
- Fracture _____
- Developmental/Growth Problems _____
- Osteoporosis

Gastrointestinal

- Indigestion
- Ulcer history
- Vomiting/nausea
- Intestinal disease
- Abdominal pain
- Blood in stools
- Hernia
- Liver disease
- Frequent diarrhea
- Gall bladder disease
- Pancreatitis
- Stones
- Rectal bleeding
- Pain in rectum

Peripheral Vascular

- Reynaud's
- Calf pain w/ walking

Cardiopulmonary

- High blood pressure
- Chest pain (angina)
- Palpitations
- Coughing up blood
- Shortness of breath
- Shortness of breath at night
- Swollen feet or ankles
- Irregular heart beat
- Heart attack

Breasts

- Lump or pain in breasts
- No Annual breast exam
- Discharge

Respiratory

- Sputum production
- Coughing up blood
- Emphysema
- Asthma
- Bronchitis
- Wheezing/gasping
- Pneumonia

Neurological

- Head injury
- Loss of consciousness
- Dizzy spells/fainting
- Numbness/tingling
- Tremors
- Seizures

Psychiatric

- Depression
- Anxiety
- Treatment
- Nervous/worry

Hematologic

- Anemia
- Easy bruising/bleeding
- Leukemia

Renal/urinary

- Kidney disease
- Bladder infections
- Frequent urination
- Night time urination
- Releasing urine when coughing/sneezing
- Blood in urine
- Burning with urination
- Incontinence

Genitoreproductive

- Sexual dysfunction
- Infertility
- Infections

Women only:

- No Annual OB/GYN exam
- Trouble with your period
- Endometriosis
- C-section delivery
- Currently pregnant

Men only:

- Prostate disease

Other: _____

Family History

Please check if any blood relative has had the following:

- | | |
|--|---|
| <input type="checkbox"/> Cancer (any) relation _____ | <input type="checkbox"/> Anemia relation _____ |
| <input type="checkbox"/> Kidney/Bladder Disease relation _____ | <input type="checkbox"/> Heart disease relation _____ |
| <input type="checkbox"/> High Blood Pressure relation _____ | <input type="checkbox"/> Arthritis relation _____ |
| <input type="checkbox"/> Diabetes relation _____ | <input type="checkbox"/> Epilepsy relation _____ |
| <input type="checkbox"/> Obesity relation _____ | <input type="checkbox"/> Allergies or asthma relation _____ |
| <input type="checkbox"/> Stroke relation _____ | <input type="checkbox"/> Tuberculosis relation _____ |
| <input type="checkbox"/> Psychological relation _____ | <input type="checkbox"/> Thyroid relation _____ |
| | <input type="checkbox"/> Other relation _____ |

Please tell us more about yourself:

Hospitalizations (including year and related surgery or illness): _____

Current Status

What is your reason for seeking physical therapy treatment?

Is this related to a specific injury or accident? (Yes/No, please explain) _____

When did this problem begin? _____

Have you or are you currently receiving any other treatment for this or another condition by another health care provider? If so when (past or present) and what kind of treatments do you receive? (ie. chiropractor, osteopath, podiatrist, etc.) _____

Have you had this injury/condition before? _____ (Yes) _____ (No) If yes, when? _____

List any sports/athletics that you participate in (including frequency/length of time/days per week) _____

Are you in any pain now? _____ (Yes) _____ (No)

Does activity provoke/increase your pain?

_____ (Yes) _____ (No)

If Yes, what activity? _____

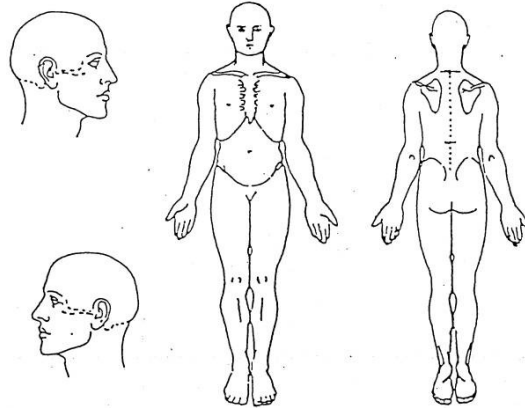
Rate the intensity of your pain/discomfort at rest
(0 = no pain, 10 = worst possible pain) circle
number:

0 1 2 3 4 5 6 7 8 9 10

Rate the intensity of your pain/discomfort with
activity:

0 1 2 3 4 5 6 7 8 9 10

Please use the body chart across and key below
to indicate the location of your pain/discomfort
A= deep ache P= Pins & Needles N=Numbness
B= burning S= sharp/knifelike ↓ = shooting pain



Patient Signature
