Florida Hospital SPORTSMEDICINE AND REHABILITATION

OUTPATIENT MEDICAL HISTORY caw 10/10/08

Name: _____ Date: _____ SS #: _____

Referring Physician: _____ Family Physician: _____

Do you have or have you ever had **ANY** of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema	___	___	Severe or Frequent Headache	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Artery Disease or Angina	___	___	Numbness or Tingling	___	___
Pacemaker	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack or Heart Surgery	___	___	Weight Loss/Energy Loss	___	___
Stroke/TIA	___	___	Bowel or Bladder Problems	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies (including drug)	___	___
Thyroid Disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Wrist/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you Pregnant?	___	___
Emotional/Psychological Problems	___	___	Do you use Tobacco?	___	___
Cortisone shot / epidural	___	___	Other: _____	___	___

If **YES** to any questions above, **please explain**:_____

_____

FALLS RISK ASSESSMENT

	YES	NO
Are you seeing a physician for dizziness or imbalance?	___	___
Do you have loss of balance or require assistance when getting up from sitting?	___	___
Do you have difficulty walking without holding onto furniture or walls?	___	___
Do you use an assistive device for walking (i.e. cane, walker, wheelchair)?	___	___

If yes, please list: _____

How many times have you fallen in the last 3 months? _____

When and how did you last fall? _____

MEDICATION LIST

(please list **ANY/ALL** medications you are currently taking, include prescribed, over the counter, vitamins, etc)

PLEASE INFORM US IF YOU BEGIN TAKING ANY NEW MEDICATIONS DURING YOUR COURSE OF THERAPY

☐ **I am currently not taking any medication including prescribed, over the counter vitamins, etc**

NAME/DOSAGE	FREQUENCY	NAME/DOSAGE	FREQUENCY
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	