Eastern Rehabilitation Network
Hartford Hospital

MEDICAL HISTORY FORM

Name:____________________________ Date of Birth:_____________ Date of Injury/Onset:______________
Allergies:____
Emergency Contact: ____________________________________ Phone ______________________________
Are you pregnant? Y / N. Please list any test results (X-ray, MRI, etc):_______________________________________
Referring MD:________________ Phone:_________ Primary Care MD: _____________Phone:_____________
Current Medications:____
____
Other MD/phone (Please list *any* other MD who is prescribing or who you are receiving care from):_______________________________

Fall Risk Assessment:

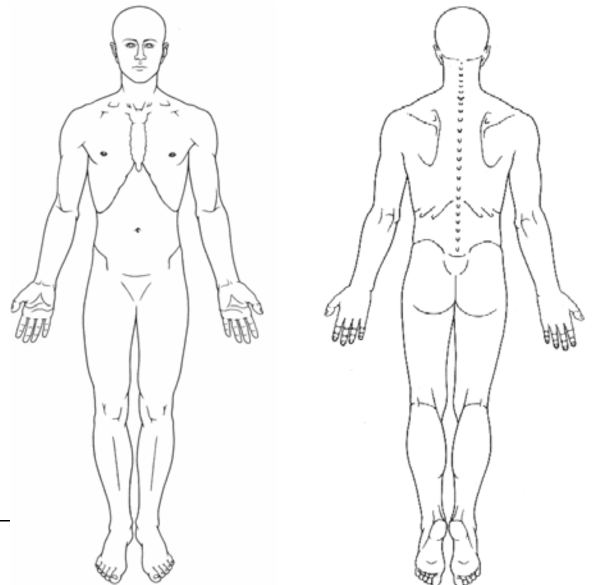
1. Have you fallen in the past year? ☐yes ☐ no Describe: ____
2. Did you sustain an injury when you fell? ☐yes ☐ no Describe: _____________________________________

Do you have any past or present history of:	**Yes**	**No**
Heart Disease, High Blood Pressure, Angina, Pacemaker?	_____	_____
Respiratory Problems, Asthma, Allergies, TB?	_____	_____
Diabetes (Any type)?	_____	_____
Arthritis(Diagnosed by M.D.)?	_____	_____
Bone Disease(s)	_____	_____
Skin Disorders, Eczema, Psoriasis, Athlete's foot?	_____	_____
Communicable Diseases, hepatitis, TB?	_____	_____
History of Cancer (Any type)?	_____	_____
Psychiatric history	_____	_____
Any metal or artificial implants?	_____	_____
Any previous injuries to the same area?	_____	_____
Any previous motor vehicle accidents with injuries?	_____	_____
Any previous surgeries?	_____	_____
Any history of neurological conditions? (seizure, stroke, etc)	_____	_____
Do you have any latex allergies?	_____	_____
Do you have any other medical conditions (please define below)	_____	_____
Do you have a Do Not Resuscitate (DNR) Order?	_____	_____

Please explain any YES answers and state date of occurrence: ______________________________________
____

In the diagram on the right, please mark the area(s) where your pain is located using the following symbols:

X = PAIN
/// = PINS AND NEEDLES
O = NUMBNESS
↓ = SHOOTING PAIN



Please rate your pain right now on a scale of 0 – 10 with 0 being no pain at all and 10 being the worst pain imaginable:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

What would you rate your pain at its lowest? /10
What would you rate your pain at its highest? /10

Please describe your pain (circle all that apply).

constant intermittent sharp dull aching burning

tingling stabbing throbbing shooting cramping

Signature: ________________________________ **Date:** ______

Revised 12/10 HHmedical history form: