Rehabilitation Services

Medical History Questionnaire

MIDWEST ORTHOPÆDIC CENTER

❒ Jeffrey W. Akeson, M.D. ❒ Nirain A. D'Souza, M.D. ❒ Michael J. Gibbons, M.D.
❒ Brent C. Johnson, M.D. ❒ Richard A. Kube, M.D. ❒ Brett R. Levine, M.D. ❒ John D. Mahoney, M.D.
❒ Michael S. Merkley, M.D. ❒ Thomas J. Mulvey, M.D. ❒ James R. Williams, M.D. ❒ Marc A. Zussman, M.D.

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM!

Name _____ Age ____ Date ___/___/___ DOB ___/___/___

Address _____
street city state zip

Telephone [home] _____ [work] _____ [cell] _____

Referring Physician _____ Date of Injury _____

EMPLOYMENT [IF APPLICABLE]

Are you employed? ❒ No ❒ Yes Are you currently working? ❒ No ❒ Yes

Place of Employment _____ Occupation _____

What are your job duties? _____

At work, do you primarily ❒ Sit ❒ Stand ❒ Walk Are you required to reach overhead? ❒ No ❒ Yes

How many pounds are you required to lift? _____ How often do you lift the weight? _____

GENERAL HEALTH STATUS

How would you rate your overall health status? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Explain any major life changes you have experienced in the past year. _____

_____

Do you smoke? ❒ No ❒ Yes Do you drink alcohol? ❒ No ❒ Yes Do you live alone? ❒ No ❒ Yes

MEDICAL/SURGICAL HISTORY - Please check if you have ever had...

❒ Arthritis	❒ Blood disorder	❒ Broken bones/fractures	❒ Cancer	❒ Depression
❒ Diabetes	❒ Growth problems	❒ Head injury	❒ High blood pressure	❒ Hypoglycemia
❒ Infectious disease	❒ Kidney problems	❒ Lung problems	❒ Multiple Sclerosis	❒ Muscular Dystrophy
❒ Osteoporosis	❒ Pacemaker	❒ Parkinson's Disease	❒ Pregnancy	❒ Repeated infections
❒ Seizures/Epilepsy	❒ Skin Diseases	❒ Stroke	❒ Thyroid problems	❒ Tuberculosis
❒ Vascular disease	❒ Ulcers/stomach problems	❒ Other _____		

Within the last year have you had any of the following symptoms? [check all that apply]

❒ Bowel problem	❒ Chest pain	❒ Coordination problems	❒ Difficulty sleeping	❒ Difficulty swallowing
❒ Difficulty walking	❒ Dizziness or blackouts	❒ Fever/chills/sweats	❒ Headaches	❒ Hearing problems
❒ Heart palpitations	❒ Hoarseness	❒ Joint pain or swelling	❒ Loss of appetite	❒ Loss of balance
❒ Nausea/vomiting	❒ Pain at night	❒ Persistent cough	❒ Shortness of breath	❒ Urinary problems
❒ Vision problems	❒ Weakness in arms/legs	❒ Weight loss/gain	❒ Other _____	

Have you ever had surgery? ❒ No ❒ Yes. Please describe and include dates: _____

_____

CURRENT CONDITION[S]/CHIEF COMPLAINT

Describe the problem for which you seek therapy. _____

_____

Exact location of problem _____ Date of injury[mm/dd/yy] _____

Have you ever had this problem before? ❒ No ❒ Yes. What did you do for the problem? _____

_____

_____

_____

6000 N. Allen Road, Peoria, Illinois 61614 309-691-1400 fax 309-693-3175

Did the problem get better? ❒ No ❒ Yes (if any) About how long did the problem last? _____

Describe how your injury began. _____

_____

_____

_____

_____

Does any position/activity make the pain better? _____

Does any position/activity make the pain worse? _____

What are your goals for therapy? _____

Please list any previous or current medical providers for this condition: _____

_____

Is any treatment received helping? ❒ No ❒ Yes. Explain: _____

Have you had any surgeries for this current condition? _____

MEDICATIONS

List all prescription and non-prescription medications you take (include dose).

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

OTHER

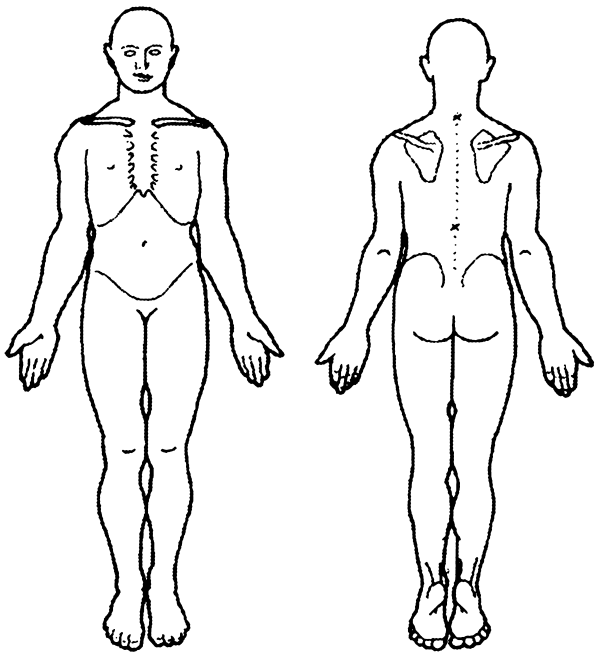
Are you involved with litigation related to the incident that resulted in your current problem? ❒ No ❒ Yes.

Do you plan to return to your previous job? ❒ No ❒ Yes.

Are you currently receiving any compensation? ❒ No ❒ Yes.

Are you willing to be an active participant in the rehabilitation of your problem? (attend PT appointments, complete a home exercise program, report any change in status) ❒ No ❒ Yes.

PLEASE MARK ON THE DIAGRAM WHERE YOUR SYMPTOMS ARE ACCORDING TO THE KEY PROVIDED.



PLEASE MAKE A SLASH ON A SCALE BELOW TO INDICATE YOUR PRESENT LEVEL OF PAIN WITH RESPECT TO YOUR IMPAIRMENT OR INJURY.

RATING SCALE: "0" IS NO PAIN AND "10" IS SEVERE PAIN.

0 _____ **10**

KEY

NUMBNESS - - - -
BURNING X X X X
ACHING M M M M
PINS/NEEDLES .....
STABBING / / / / /

_____
signature date

_____
Therapist signature date

6000 N. Allen Road, Peoria, Illinois 61614 309-691-1400 fax 309-693-3175