BERGER HEALTH SYSTEM
Physical Medicine & Rehabilitation

Medical History Form

Patient: _____

Are you on any medications? Please list: _____

_____

☐ Medication List Supplied

Have you ever had any of the following? ☐ EMG ☐ CT Scan ☐ MYELOGRAM ☐ MRI ☐ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Back Injury	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No
Fracture	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Metal Implants	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Hernia	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Bowels / Bladder Abnormalities	☐ Yes	☐ No
Liver / Gallbladder Problems	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
List:		
Other: (Continue Below if needed)		

Ringing in your ears	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
Surgeries	☐ Yes	☐ No
List with dates:		

Please check all that may apply. My pain is worse:

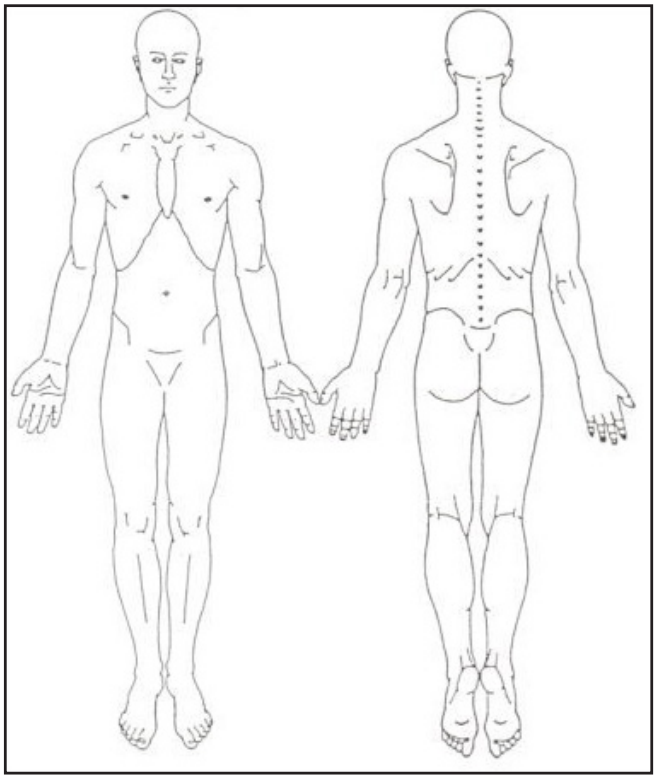
In the morning ☐ During the day ☐ At Night ☐

Constant ☐ With Activity ☐ During rest ☐

With 0 being no pain and 10 being unbearable pain requiring hospitalization:
Please rate your pain at its best _____ at its worst _____
Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

KEY

+++ Radiating Pain
XXX Spasm
ZZZ Tenderness
///// Numbness / Tingling
000 Ache / Pain



Signature of Patient or Guardian (if patient is a minor): _____Date: _____
Relationship to patient: ☐ Self ☐ Guardian ☐ Other

Clinician's Signature: _____Date: _____