LABEL

Stony Brook Medicine

STONY BROOK MEDICINE HAND THERAPY MEDICAL HISTORY FORM

Name: _____ **Daytime phone #**:_____
Occupation:_____
Hobbies:_____
· Date of injury / accident / disease_____ ·Date of surgery_____ · Right / Left hand dominant
· Describe your symptoms and the reason for this appointment:
_____
_____
_____
· When are you scheduled to return to your referring physician? _____
· Have you had PT/OT or chiropractor elsewhere for your current condition? _____
_____

Pain Management:
Please indicate your pain at rest _____ and with activity_____: 0-10 **(0 = NO PAIN; 10 = WORST PAIN EVER)**

Past Medical History:
Have you ever had any of the following conditions? ***Check all that apply.***

□High blood pressure
□Heart condition
□Stroke
□Osteoporosis
□Peripheral Neuropathy
□Seizures/epilepsy
□Pacemaker / Defibrillator
□Allergies_____
□Lupus or other Rheumatic disorder_____
□Arthritis (Rheumatoid or Osteoarthritis)_____
□Diabetes
□Cancer_____
□Lymphedema
□Fainting/dizziness
□Vision problems
□Frequent or severe headaches
□HIV /AIDS
□Other:_____

Do you have a history of fractures? YES / NO Where? _____
Do you have any metal implants? YES / NO Where? _____
Do you smoke -YES / NO? Past / Present? Number of years? _____ Number of packs per day? ____

Diagnostic Tests: Please check any tests or procedures that have been done for your **current** condition.
□X-rays □MRI □CT scan □Bone scan □EMG □Blood work □Bone density □Ultrasound

Medications:
Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking:_____
_____
_____

Surgeries: Please list all surgeries including dates:_____

Functional difficulties: ***Please CIRCLE those which you have difficulty with.***

DOOR KNOBS STARTING A CAR BUTTONS ZIPPERS SHOELACES BELT BUCKLE

CAR DOORS HAIR DRYER SHAVING MEAL PREPARATION FEEDING SELF DRIVING

BATHING HANDLING MONEY OPENING JARS & BOTTLES WRITING LIFTING

Please sign acknowledging review of this information:

Patient signature: _____ **Therapist signature:**_____ **Date:**_____ **Time:**_____