

ORTHOPAEDIC SPORTS, INC.

WOMEN'S HEALTH MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name: _____				Today's Date: _____	
Date of Birth: _____	Age: _____	Height: _____	Weight: _____	Do You Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who referred you to physical therapy? _____			Primary Physician: _____		

Who is your employer? _____ **What is your job title/responsibilities?** _____
 Are you currently working? No Yes If yes, number of hours per week _____ Full Duty Restricted Duty
 How may work days missed due to this condition? _____ Do you have a case manager/QRC? No Yes

Have you ever been diagnosed with any of the following? (Circle all that apply)

Arthritis	Hepatitis	Abdominal Pain
Cancer	Irritable Bowel Syndrome	Bladder Infections
Diabetes	Multiple Sclerosis	Headaches
Endometriosis	Stroke	Low back pain/Sciatica
Epilepsy	STD/HIV/AIDS	TMJ
Fibromyalgia	Tuberculosis	Sensitivity to latex
Heart Disease	Respiratory Problem	Other: _____

Please answer the following questions about your OB/Gyn History.

Number of vaginal deliveries _____
 Number of C-Sections _____
 Number of episiotomies/tears _____
 Have you reached Menopause Y/N

Describe any complications to your pregnancy or delivery: _____

Why have you been referred to Physical Therapy? _____
When did you first notice the pain or have functional problems due to the condition/injury? (Specific date) - ___/___/___
Recent flare-up? If yes, when ___/___/___ **What activities are limited by this condition? (e.g. lift, cough, intercourse)** _____

Where and how did your injury/symptoms occur? Recreation Home Work Auto Accident Unknown Other _____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: Constant? Intermittent? Getting Better?
 Getting worse? Staying the same?

What makes your symptoms better? _____
 What makes your symptoms worse? _____

0-10 pain scale (0 = No Pain; 10 = The Most Extreme Pain)
Worst pain rating: _____ **Best pain rating:** _____ **Current pain rating** _____
 Describe your pain: (e.g. burn, sharp/dull) _____

For this injury, has your medical care included:(check those that apply)

Surgical History: When? ___/___/___ What kind? _____
 When? ___/___/___ What kind? _____
 When? ___/___/___ What kind? _____

Diagnostic tests: MRI CT scan Urodynamics Xray Other
 Results _____

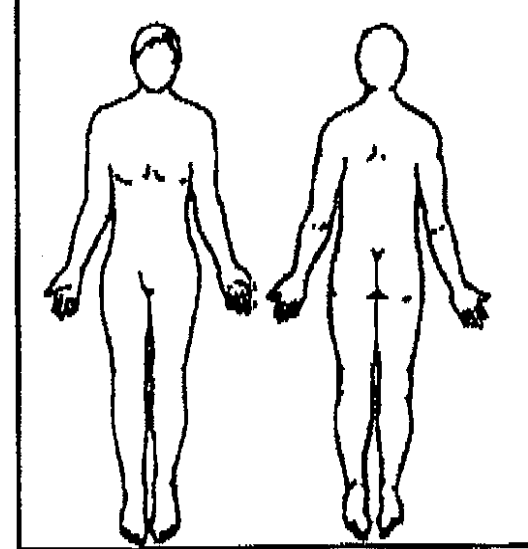
List current medications: _____

Other treatments received for this condition (e.g. acupuncture, chiropractor etc): _____

Do you exercise regularly? Y/N What type? _____

Indicate on body diagrams where your symptoms are located

■ = Pain III = Numbness



Additional Comments: _____