

The Hand Therapy Center of Omaha Medical History

Name: _____ Age: _____ Date: _____

Please check below if you currently have, or have had a history of the following:

High Blood Pressure		Headache	
Cardiac History		Dizziness/Fainting	
Pacemaker		Multiple Sclerosis	
Stroke		Muscular Dystrophy	
Circulation disorder/blood clots		Current/recent pregnancy	
Bowel/bladder incontinence		Smoking	
Diabetes		Prior neck/back problems	
Asthma		Major joint injuries	
Respiratory illness/lung disease		Osteoporosis	
Hepatitis/Tuberculosis		Arthritis	
Cancer		Latex sensitivity	
Seizures		Visual impairment	
Hearing impairment			

Other (please explain): _____

Surgeries:

Medications:

Allergies:

Pain rating today: (please refer to chart below and circle one)

no pain	mild pain	moderate pain	severe	very severe	worst possible					
0	1	2	3	4	5	6	7	8	9	10