SCOTTSDALE HEALTHCARE®

Patient Label

# MEDICAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Do you currently have or have you had in the past any of the following:

| | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|
| Pacemaker/Defibrillator | | | Balance Problems | | | Depression | | |
| Breathing/Respiratory Problems | | | Incontinence-Bowel/ Bladder problems | | | Swelling in extremities | | |
| | | | | | | Polio | | |
| Back Trouble | | | Eye Problems | | | Stroke/TIAs | | |
| Diabetes | | | Headaches | | | Osteoporosis | | |
| Cancer | | | Blood Clots/DVTs | | | Dizziness | | |
| High Blood Pressure | | | Anemia | | | Epilepsy/Seizures | | |
| Low Blood Pressure | | | Supplemental Oxygen | | | Ear Trouble | | |
| Musculoskeletal Problems | | | Speech/Language Problems | | | Infection/Unhealed Wounds | | |
| Chest Pain | | | Kidney Problems | | | Wear Orthotics | | |
| Cardiac/Heart Problems | | | Nausea/Vomiting | | | Skin Disease | | |
| Broken bones/Fractures | | | Arthritis Location: _____ | | | Smoke PPD _____ Years _____ | | |
| Stomach Trouble | | | | | | | | |
| Swallowing Problems | | | Tuberculosis | | | Voice Problems | | |

Please explain all YES answers: _____

_____

_____

_____

Please List Significant Diagnoses, Conditions, or Major Injuries:

1. _____ 2. _____

3. _____ 4. _____

Please List any Surgeries with dates:

1. _____ 2. _____

3. _____ 4. _____

Do you have eating or swallowing difficulties? ☐ Yes ☐ No If yes, describe: _____

_____

Do you have speech, language, voice, or cognitive problems? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

DTOPT

Please list all medications you are taking, including all prescription, over-the-counter, and herbal.

1. _____ For what: _____ How often taken: _____

2. _____ For what: _____ How often taken: _____

3. _____ For what: _____ How often taken: _____

4. _____ For what: _____ How often taken: _____

5. _____ For what: _____ How often taken: _____

6. _____ For what: _____ How often taken: _____

7. _____ For what: _____ How often taken: _____

8. _____ For what: _____ How often taken: _____

9. _____ For what: _____ How often taken: _____

Do you have any allergies, including drug allergies? ☐ Yes ☐ No To what and how does it effect you: _____

Is there a possibility that you are pregnant? ☐ Yes ☐ No

Do you have an advanced directive/living will? ☐ Yes ☐ No
Please explain your resuscitation specifications: _____

Is there anything else that we should know? _____

_____

Patient's Signature: _____ Date: _____