



Griffin Hospital

Griffin Hospital Rehabilitation Services

350 Seymour Avenue, Derby, CT 06418

Phone (203) 732-7445 Fax (203) 732-7395

PATIENT MEDICAL HISTORY

Name: _____ DOB _____ Date: _____

- Are you receiving any home care services such as visiting nurse, home health aide, homemaker, or therapy? Yes No Are you currently participating in Cardiac Rehabilitation? Yes No
- What are your present symptoms and when did they start? _____

➤ Do you have pain? Yes No Numbness or tingling? Yes No

➤ On a scale of 1 – 10, with 10 being excruciating pain, how would you rate your pain?

1 2 3 4 5 6 7 8 9 10

➤ How would you describe your pain? *Sharp Dull Throbbing Burning Aching Constant Intermittent*
(circle all that apply)

➤ What makes your pain better? _____

➤ What makes your pain worse? _____

➤ Height: _____ Weight: _____

➤ Are you pregnant? Yes No

➤ Do you have any contagious diseases? Yes No

➤ Have you fallen? Yes No Date of most recent fall _____

➤ Past Medical History: _____

➤ Past Surgical History: _____

Any metal implants? Yes No Location: _____

➤ Were you injured at work or in a car accident? Yes No

➤ If "Yes", what type of injury and date of injury? _____

Please mark the location of your pain:

Numbness
|||||

Pins and Needles
00000

Burning
x.x.x.x

Stabbing
|||||

Ache



