The Saratoga Hospital
Regional Therapy Center
211 Church Street • Saratoga Springs, NY 12866
(518) 583-8383

Medical History

Last Name	*First Name*	*MI*
Inpatient Account Number	*Room Number*	
HO Number	*DOB*	
Physician		

	Yes	No	If yes, please specify	Updated
Allergies	☐	☐		☐
Arthritis	☐	☐		☐
Diabetes	☐	☐		☐
High blood pressure	☐	☐		☐
Stroke	☐	☐		☐
Heart conditions	☐	☐		☐
Seizures	☐	☐		☐
Cancer	☐	☐		☐
Injuries (e.g. fractures, sprains, etc.)	☐	☐		☐
Back/neck problems	☐	☐		☐
Persistent cough	☐	☐		☐
Difficulty breathing	☐	☐		☐
Difficulty swallowing	☐	☐		☐
Abdominal pain	☐	☐		☐
Bowel/bladder problems	☐	☐		☐
Persistent headaches	☐	☐		☐
Vision/hearing problems	☐	☐		☐
Rash/Skin problems	☐	☐		☐
Bleeding disorder	☐	☐		☐
Dizziness, lightheaded	☐	☐		☐
Tobacco use	☐	☐		☐
Alcohol Use	☐	☐		☐
Pregnant now	☐	☐		☐
Recent illness or exposure to:				
Chicken pox	☐	☐		☐
Measles	☐	☐		☐
Mumps	☐	☐		☐

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Physician _____

Are you on a prescribed/special diet? ☐ Yes ☐ No

If yes, do you have any questions about your diet? ☐ Yes ☐ No

Do you have any medical concerns or questions at this time? ☐ Yes ☐ No

If yes, please explain: _____

Have you been hospitalized in the past 3 years? ☐ Yes ☐ No

If yes, when and for what reason, including surgery: _____

Please list all medications (prescription and over the counter) that you are taking at this time: (or attach your list)

Name of Medication	*Reason*	*Doctor Prescribing*	*Updated*
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Do you have any questions regarding any of your medications? ☐ Yes ☐ No

Have you had any of the following before?

	Yes	No	(If so, what for?)
Physical Therapy	☐	☐	_____
Occupational Therapy	☐	☐	_____
Speech Therapy	☐	☐	_____
Other therapies	☐	☐	_____

Are you currently receiving any type of home care, therapy or chiropractic care? ☐ Yes ☐ No

If yes, please describe type and frequency: _____

Do you have any hospital equipment, therapy equipment, or exercise equipment? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any difficulties taking care of yourself and/or working? ☐ Yes ☐ No

If yes, please describe: _____

Is the injury or problem you will be receiving therapy for today related to : ☐ Motor Vehicle Accident ☐ Work-Related Incident

What is your expectation for either your visit or treatment outcome? _____

_____ _____

Patient or Representative Signature *Date*

_____ _____

Patient or Representative Signature *Updated on*