RehabHealth
Leaders in Rehabilitation Medicine

PATIENT MEDICAL INFORMATION

Name: _____ **Date of Birth:** _____ **Age:** _____

Referring Physician: _____ **Primary Care Physician:** _____

HISTORY OF PRESENT PROBLEM

Brief reason for today's visit: _____

_____

Was this a motor vehicle accident? □ yes □ no -or- **Work Injury** □ yes □ no -or- **Other** □ yes □ no
* If this is a motor vehicle accident, was it work related? □ yes □ no

Date of injury or onset of problem: _____

If this is an injury, do you have an attorney for this problem? □ yes □ no
* If yes, Attorney Name: _____

Do you have pain? □ yes □ no * If yes, which body part? _____
Do you have numbness or tingling? □ yes □ no * If yes, which body part? _____
Do you have weakness? □ yes □ no * If yes, which body part? _____

Are your symptoms associated with: (circle all that apply)
Swelling Dropping Objects Falling or "Giving Way" Locking of a Joint Catching of a Joint
Loss of Motion Increased Warmth Other: _____

If you have pain, how would you describe it? (circle all that apply)
Sharp Dull Ache Burning Electric-Like Other: _____

How intense is your pain if "0" is no pain and "10" is the worst pain? On average: ____ At the worst: ____

What makes your symptoms worse?
Sitting □ yes □ no
Standing □ yes □ no
Walking □ yes □ no
Other: _____

Studies done for this problem: (indicate facility)
□ X-Rays _____
□ MRI _____
□ CT Scan _____
□ Nerve Tests _____
□ Blood Work _____
□ Bone Scan _____

What makes your symptoms better?
Rest □ yes □ no □ not tried
Heat □ yes □ no □ not tried
Ice □ yes □ no □ not tried
Bracing □ yes □ no □ not tried
Physical Therapy □ yes □ no □ not tried
Home Exercise □ yes □ no □ not tried
Acupuncture □ yes □ no □ not tried
Chiropractic □ yes □ no □ not tried

Medications that help: _____
Medications that do *not* help: _____
Injections tried: (where/type) _____
_____

Have you ever injured this body part at any other time in the past? □ yes □ no
* If yes, please briefly describe: _____

Initial _____ **Date** _____

MEDICAL HISTORY

Please check below with regard to your medical history:

Heart Disease	□ yes □ no	**Asthma**	□ yes □ no	**Gout**	□ yes □ no
Diabetes	□ yes □ no	**Hepatitis**	□ yes □ no	**Lung Problems**	□ yes □ no
Hypertension	□ yes □ no	**Ulcers**	□ yes □ no	**Thyroid**	□ yes □ no
Stomach Problems	□ yes □ no	**Seizures**	□ yes □ no	**AIDS/HIV+**	□ yes □ no
Kidney Problems	□ yes □ no	**Cancer**	□ yes □ no	**Blood Clots**	□ yes □ no
High Cholesterol	□ yes □ no	**Other:** _____			

Prior Surgery (please check all that apply and add year)

___ **Never had surgery**
___ **Spinal** Type/Level _____ With fusion? □ yes □ no Year _____
___ **Neck** Type/Level _____ With fusion? □ yes □ no Year _____
___ **Low Back** Type/Level _____ With fusion? □ yes □ no Year _____
___ **Carpal Tunnel** □ Right □ Left Year(s) _____
___ **Tendon or Ligament Repair** Body Part _____ □ Right □ Left Year _____
___ **Hernia Repair** Body Area _____ □ Right □ Left Year _____
___ **Knee Surgery** Type _____ □ Right □ Left Year _____
___ **Hip Surgery** Type _____ □ Right □ Left Year _____
___ **Shoulder Surgery** Type _____ □ Right □ Left Year _____
___ **Intestinal Surgery** Type _____ Year _____

___ **Hysterectomy**	Year _____	___ **Appendectomy**	Year _____
___ **Gall Bladder**	Year _____	___ **Tubal Ligation**	Year _____
___ **Vasectomy**	Year _____	___ **Coronary Bypass**	Year _____
___ **Cardiac Valve Replacement**	Year _____	___ **Leg Artery Bypass**	Year _____
___ **Pilonidal Cyst**	Year _____	___ **Mastectomy**	Year _____
___ **Pacemaker** `	Year _____	___ **Bunion** □ Right □ Left	Year _____
___ **Thyroid**	Year _____	___ **Tonsils**	Year _____

___ **Other:** _____ Year _____
___ **Other:** _____ Year _____
___ **Other:** _____ Year _____

FAMILY HISTORY

Parents/Siblings: *Ages & Health* (If deceased, please indicate age at death and cause)

_____
_____
_____
_____

Does anyone in your family have any of the following? (Please specify type if known and relationship to you)
___ **Joint Problems** (other than wear and tear with age) _____
___ **Nerve Diseases** _____
___ **Rheumatological Problems/Rheumatoid Arthritis/Psoriasis/Lupus** _____
___ **Developmental Bone Problems** _____

Initial _____ **Date** _____

MEDICATIONS & ALLERGIES

Medications (Include prescription, over the counter, vitamins and supplements)

Medicine	Dose	# Times Per Day	Medicine	Dose	# Times Per Day

Drug Allergies and Sensitivities

___ No known allergies
___ Latex Reaction _____
___ Iodine, Seafood, IV Contrast Material Reaction _____
___ **Food** Food(s) & Reaction(s) _____

Please indicate all other drug allergies and sensitivities below:

Name _____ Reaction _____ Name _____ Reaction _____
Name _____ Reaction _____ Name _____ Reaction _____
Name _____ Reaction _____ Name _____ Reaction _____
Name _____ Reaction _____ Name _____ Reaction _____

SOCIAL HISTORY

Are you (please circle): Single Married Widowed Separated Non-Married Relationship

Employment status: Full-Time Part-Time Unemployed Student Retired Disabled

What is your occupation? _____

Do you have children? □ yes □ no * If yes, how many? _____

Do you consume alcohol? □ yes □ no * If yes: Type _____ Amount _____ Frequency _____

Do you use street drugs? □ yes □ no * If yes: Type _____ Amount _____ Frequency _____

Do you smoke cigarettes? (Please select one of the following choices)
___ 0 Cigarettes per day (non-smoker or less than 100 in lifetime)
___ 0 Cigarettes per day (previous smoker)
___ Few (1-3) Cigarettes per day
___ Up to 1 pack per day
___ 1-2 packs per day
___ 2 or more packs per day

Other tobacco products? □ yes □ no * If yes: Type _____ Amount _____ Frequency _____

What is your: Height _____ Weight _____

Initial _____ **Date** _____

GENERAL HEALTH REVIEW

I am: ☐ **Left Handed** ☐ **Right Handed**

1. Recent weight change? **yes** ☐ **no** ☐
If "yes" please circle: loss / gain . . . amount: _____ pounds

2. Bladder / Urinary problems? **yes** ☐ **no** ☐
If "yes" please circle: burning / frequency / difficulty going / incontinence

3. Bowel complaints? **yes** ☐ **no** ☐
If "yes" please circle: constipation / diarrhea / color change

4. Nausea or vomiting? **yes** ☐ **no** ☐

5. Fever / Chills? **yes** ☐ **no** ☐

6. Shortness of breath or cough? **yes** ☐ **no** ☐

7. Rash? **yes** ☐ **no** ☐

8. Peripheral edema / swelling in ankles? **yes** ☐ **no** ☐

9. Cardiac palpitations? **yes** ☐ **no** ☐

10. Anxiety? **yes** ☐ **no** ☐

11. Depression? **yes** ☐ **no** ☐

12. Hearing change? **yes** ☐ **no** ☐

13. Visual change? (other than glasses) **yes** ☐ **no** ☐

14. Dizziness? **yes** ☐ **no** ☐

15. Headaches? **yes** ☐ **no** ☐

16. Easy bruising? **yes** ☐ **no** ☐

17. Chest pain? **yes** ☐ **no** ☐

If you answered "Yes" to any of the above, please explain below:

_____

_____

_____

Signature: _____ **Date:** _____