Rehabilitation Physicians Inc. | Medical History *(pg. 1 of 3)*

Date:_____

Name _____ Age _____ Birth Date _____

Address _____ Sex ☐ Male ☐ Female

(line 2) _____ SSN# _____

Occupation _____ Home Phone _____

Email _____ Cell/Work Phone _____

Emergency Contact Name _____ Emergency Contact Phone _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Married, Spouse's Name _____

Children's Names & Ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances: ☐ No ☐ Yes

If yes, please list name(s) of medicine and types of reaction.

_____

_____

_____

_____

Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Lower back problems
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain/loss	☐ Skin diseases
☐ Cancer	☐ Persistent cough	☐ Hemmorhoids	☐ Blood disorders
☐ Heart Disease	☐ Tuberculosis	☐ Gall Bladder disease	☐ Venerial diseases
☐ Chest pain/tightness	☐ Hay fever	☐ Colitis	☐ Anxiety
☐ Shortness of breath	☐ Abdominal discomfort	☐ Hepatitis of jaundice	☐ Depression
☐ Swollen Ankles	☐ Indigestion	☐ Thyroid disease	☐ Anemia
☐ Palpitations	☐ Nausea	☐ Head or neck radiation	☐ Alcohol abuse
☐ Hepatitis C	☐ Vomiting	☐ Headaches/Migraines	☐ Drug abuse
☐ Frequent urination	☐ Constipation	☐ Kidney disease	☐ Psychiatric illness
☐ AIDS	☐ Diarrhea	☐ Kidney stones	☐ Impotence or Erectile Dysfunction
☐ Rheumatic Fever	☐ Blood in stool	☐ Difficulty urinating	☐ Bipolar disorder
☐ Asthma	☐ Ulcers	☐ Arthritis	☐ OTHER

If you checked any above, please explain: _____

_____

_____

_____

Gynecologic and Obstetric History

Age at onset of period _____ Frequency _____ Length of period _____

Pregnancies_____ Births _____ Miscarriages _____

Prolonged/abnormal bleeding ☐ No ☐ Yes *(please describe)* _____

Leakage of urine ☐ No ☐ Yes *(please describe)* _____

Pelvic Pain ☐ No ☐ Yes *(please describe)* _____

Abdominal discharge ☐ No ☐ Yes *(please describe)* _____

History of abnormal pap smear ☐ No ☐ Yes *(please describe)* _____

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations (other than for surgery): _____ _____

_____ _____ _____

Immunization History *(have you had any of the following immunizations?)*:

Hepatitis B? ☐ No ☐ Yes *When?* _____ Pneumovax immunization? ☐ No ☐ Yes *When?* _____

Tetanus? ☐ No ☐ Yes *When?* _____ Flu immunization? ☐ No ☐ Yes *When?* _____

Other? ☐ No ☐ Yes *When?* _____

When was your last:

Pap Smear? _____ Breast Exam? _____ Colon Cancer Test? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History *(Have any member of your family, including parents, grandparents, and siblings, ever had ony of the following?)*:

Illness	Which family members?	Age when diagnosed?
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
OTHER	_____	_____

Rehabilitation Physicians Inc. | Medical History (pg. 3 of 3)

Medications *(prescriptions, over-the-counter, vitamins, herbs, etc.)*:

Drug Name & Dosage	Drug Name & Dosage	Drug Name & Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prevention

Do you wear seatbelts? ☐ No ☐ Yes *If no, why not?* _____

Do you wear a bike helmet? ☐ No ☐ Yes ☐ N/A

Do you exercise regularly? ☐ No ☐ Yes *If yes, describe type, duration, # of times/wk:* _____

_____

Do you smoke? ☐ No ☐ Yes *If yes, how many packs a day?* _____

Do you drink alcoholic beverages? ☐ No ☐ Yes *If yes, how much per week?* _____

Do you drink coffee? ☐ No ☐ Yes *If yes, how many cups a day?* _____

Do you drink tea? ☐ No ☐ Yes *If yes, how many cups a day?* _____

If there is a gun in your home, do you keep it unloaded and out of children's reach? ☐ No ☐ Yes ☐ N/A

Do you use drugs? (prescription pain medicine, heroin, benzodiazepine, methamphetamine, cocaine, etc.) ☐ No ☐ Yes *If yes, explain: ↓ ↓*

_____

Have you ever engaged in any activity which has put you at risk for getting AIDS? ☐ No ☐ Yes *If yes, explain:* _____

_____

Do you want to be tested for AIDS? ☐ No ☐ Yes

Have you worked with chemicals, paints, asbestos or other hazardous chemicals? ☐ No ☐ Yes *If yes, explain:* _____

_____

Are you in a relationship where you have been physically hurt (e.g., slapped, kicked, punched, bruised, etc) by your partner? ☐ No ☐ Yes

Do you feel afraid of your partner? ☐ No ☐ Yes ☐ N/A

Do you have a "living will"? ☐ No ☐ Yes

Do you have an organ donor card? ☐ No ☐ Yes

Do you use birth control? ☐ No ☐ Yes *If yes, what is your method of birth control?* _____

_____

What hobbies do you have and what do you like to do in your spare time? _____

Signature of Patient: _____ **Date:** _____

NOTE: This information is for use by your physician as part of your confidential medical record.