

**Institute of Physical Medicine & Rehabilitation  
Medical History and Review Form**

Acct # / Pat ID: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Dr. Phone: (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Fam. Dr. Phone: (\_\_\_\_) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Other

*In Case of an emergency, nearest relative or friend/guardian:*

EMERGENCY CONTACT NAME: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

I am seeking medical attention today for: \_\_\_\_\_

When did your current symptoms begin? \_\_\_\_\_

Occupation: \_\_\_\_\_ Job Duties: \_\_\_\_\_

**I am currently:** Working : \_\_\_\_\_ Full-Time \_\_\_\_\_ Part-Time \_\_\_\_\_ Not Working  
\_\_\_\_\_ Regular Duties \_\_\_\_\_ Modified Duties \_\_\_\_\_ Return to work with Restrictions  
\_\_\_\_\_ Temporarily unable to work due to condition \_\_\_\_\_ Retired \_\_\_\_\_ Disabled

Are symptoms related to MVA or Work Injury? \_\_\_\_\_ MVA \_\_\_\_\_ WORK

Date of this Event? \_\_\_\_\_ Date Last Worked: \_\_\_\_\_

**X-RAYS, MRI'S OR CT SCANS (within the last 2 years)**

*What was done?*

*Where?*

_____	_____
_____	_____
_____	_____
_____	_____

**SOCIAL HISTORY:**

Do you smoke? YES \_\_\_\_\_ NO \_\_\_\_\_ How much? \_\_\_\_\_

Do you drink alcohol? YES \_\_\_\_\_ NO \_\_\_\_\_ How much? \_\_\_\_\_

Substance abuse? YES \_\_\_\_\_ NO \_\_\_\_\_ How often? \_\_\_\_\_

**FAMILY HISTORY:** (Please check IF YES for each of the following)

*How Related*

High Blood Pressure: \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Stroke: \_\_\_\_\_

Diabetes: \_\_\_\_\_

<u>PAST MEDICAL HISTORY:</u>	(Please check IF YES for each of the following)
Explain	Explain
_____ Anemia/Blood Diseases _____	_____ Heart Attack / Angina _____
_____ Arthritis _____	_____ Heart Disease _____
_____ Asthma _____	_____ Heart Pacemaker _____
_____ Autoimmune Disease _____	_____ High Blood Pressure _____
_____ Bladder/Kidney Disease _____	_____ Irregular Heartbeat _____
_____ Cancer: _____	_____ Joint Replacements _____
_____ Carotid Artery Disease _____	_____ Memory Loss/Alzheimer _____
_____ Chronic Skin Conditions _____	_____ Osteoporosis _____
_____ Congestive Heart Failure _____	_____ Pacemaker or defibrillator _____
_____ Diabetes _____	_____ Pneumonia _____
_____ Dizziness _____	_____ Psychiatric Disorder _____
_____ Ear, Nose, Throat Problems _____	_____ Radiation/Chemo _____
_____ Emphysema/Bronchitis _____	_____ Seizures _____
_____ Falls _____	_____ Stroke _____
_____ Fractures; where _____	_____ Thyroid Disease _____
_____ Gastrointestinal Disease _____	_____ Vision Problems _____

**If yes, YEAR**

Have you ever been tested positive for Tuberculosis? \_\_\_\_\_ NO \_\_\_\_\_ YES \_\_\_\_\_

Was treatment recommended? \_\_\_\_\_ NO \_\_\_\_\_ YES \_\_\_\_\_

Did you receive treatment? \_\_\_\_\_ NO \_\_\_\_\_ YES \_\_\_\_\_

Do you currently exhibit any of the following?

Severe tiredness, weakness _____ NO _____ YES	Severe loss of appetite _____ NO _____ YES
Rapid, unexplained weight loss _____ NO _____ YES	Night sweats _____ NO _____ YES
Productive cough (sputum) _____ NO _____ YES	Low grade fever _____ NO _____ YES
Blood in sputum _____ NO _____ YES	

<u>For Women Only</u>	NO	YES	What month are you expecting?
Are you pregnant?	_____	_____	_____
Are you nursing?	_____	_____	
Are you on birth control pills?	_____	_____	
Are you trying to get pregnant?	_____	_____	

Is your family physician aware of the above listed conditions to which you answered yes? \_\_\_\_\_ NO \_\_\_\_\_ YES

Please be advised that it is your responsibility to follow up with your family physician for the above listed conditions.

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If you have Diabetes, are you on medication? \_\_\_\_\_ NO \_\_\_\_\_ YES

(If yes, please include on Medication List)

**OTHER MEDICAL HISTORY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY (What / When):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are there special needs your healthcare professional should be aware of:**

Culturally \_\_\_\_\_

Language \_\_\_\_\_

Spiritually \_\_\_\_\_

Educational \_\_\_\_\_

Transporation \_\_\_\_\_

**I have help at home from:**

\_\_\_\_\_ Family \_\_\_\_\_ Home Health Care-Bath Aide/Nurse

\_\_\_\_\_ Community Care \_\_\_\_\_ D.O.R.S. \_\_\_\_\_ No help needed

**I learn best by:**

\_\_\_\_\_ Verbal Explanation \_\_\_\_\_ Written Directions \_\_\_\_\_ Instruct my family/caretaker

**I also see:**

\_\_\_\_\_ Massage Therapist \_\_\_\_\_ Acupuncturist \_\_\_\_\_ Chiropractor

\_\_\_\_\_ Pain Clinic \_\_\_\_\_ Other: \_\_\_\_\_

An Injury or Disability can bring changes to a person's life that are sometimes difficult to manage. Do you feel you need counseling to deal with your current life situation? \_\_\_\_\_ YES \_\_\_\_\_ NO

If you wish to schedule an appointment for this purpose, you will be responsible for the Initial Consultation fee of \$35.00, if your insurance does not pay for this initial visit.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature

Date

Printed Name

