REHABILITATION SERVICE
MEDICAL HISTORY FORM

Name: _____ Date: _____

Referring Physician: _____ Family Physician: _____

Chief Complaint _____

Have you EVER had any of the following conditions?

	YES	NO	NOT SURE	EXPLANATION
Cardiac (heart problems)	___	___	____	_____
Pacemaker	___	___	____	_____
Chest, Jaw, or left Arm Pain	___	___	____	_____
Respiratory	___	___	____	_____
Shortness of Breath	___	___	____	_____
Seizures (epilepsy)	___	___	____	_____
Stroke	___	___	____	_____
Hypertension (high blood pressure)	___	___	____	_____
Dizziness or Fainting	___	___	____	_____
Arthritis Joint Disease	___	___	____	_____
Fractures (broken bones)	___	___	____	_____
Cancer	___	___	____	_____
Surgery	___	___	____	_____
Vision problems	___	___	____	_____
Hearing Difficulties	___	___	____	_____
Are you taking any medications	___	___	____	_____
List any medications	_____			
Allergies	_____			
Are you pregnant?	___	___	____	_____
Are you a nervous person?	___	___	____	_____
Are you under a physician's care for any other condition?	___	___	____	_____

Name and telephone number of person to call in case of an emergency _____

_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

_____ _____

Signature Date