# MEDICAL HISTORY

Name: _____ Age: _____ Social Security #: _____-_____-_____
Referring Doctor: _____ Family Doctor: _____
Address: _____ Address: _____
Phone #: _____ Phone #: _____

Reason for Visit: _____
Date of Injury/Onset of Symptoms: _____
Please check all prior treatments/tests for this condition and approximate dates:

___ X-ray ___/___/___ ___ Blood Work ___/___/___ ___ EMG/NCS ___/___/___
___ MRI ___/___/___ ___ Physical Therapy ___/___/___ ___ Injections ___/___/___
___ CAT Scan ___/___/___ ___ Chiropractic Manipulation ___/___/___ ___ Other _____

**Please check if you <u>currently</u> have any of the following:**

___ Fever/Chills
___ Swallowing Difficulty
___ Chest Pain/Angina
___ Irregular Heart Beat
___ Shortness of Breath
___ Cough
___ Wheezing
___ Fainting
___ Hearing Loss
___ Depression
___ Weight Gain
___ Weight Loss
___ Constipation
___ Diarrhea
___ Nausea/Vomiting
___ Poor Appetite
___ Loss of Bladder/Bowel Control
___ Weakness
___ Blood in Urine
___ Blood in Stools
___ Swelling of Ankles
___ Bruise Easily
___ Skin Condition
___ Sore(s) That Won't Heal
___ Headache
___ Neck Pain
___ Back Pain
___ Pain in Arms R/L
___ Pain in Legs R/L
___ Trouble Sleeping
___ Knee Pain
___ Hip Pain
___ Shoulder Pain
___ Pregnant
___ Numbness/Tingling - If so, where? _____

**Please check if you have had or currently have any of the following:**

___ Atrial Fibrillation
___ Heart Problems
___ Heart Attack/Failure
___ Heart Surgery
___ Pacemaker
___ High Blood Pressure
___ High Cholesterol
___ Anemia
___ Blood Clots/DVT
___ Poor Circulation
___ Pneumonia
___ Bronchitis
___ Emphysema
___ Asthma
___ Heart Burn/GERD/Reflux
___ Irritable Bowel Syndrome
___ Stomach Ulcers
___ Diabetes
___ Neuropathy
___ Spinal Cord Injury
___ Thyroid Disease
___ Kidney Problems
___ Glaucoma
___ Cataracts
___ Hepatitis
___ Poliomyelitis
___ Rheumatoid Arthritis
___ Osteoarthritis
___ Fractures
___ Osteoporosis
___ Fibromyalgia
___ Seizures/Epilepsy
___ Multiple Sclerosis
___ Parkinson's Disease
___ Stroke/TIA's
___ Depression
___ Anxiety
___ Chemical Dependency
___ Cancer
___ Other _____

**Please list all hospitalizations, surgeries, and serious injuries and approximate dates:**

_____ ____/____/____ _____ ____/____/____
_____ ____/____/____ _____ ____/____/____
_____ ____/____/____ _____ ____/____/____

**Please list any illnesses or diseases that run in the family:**

_____

_____

**Please list all current medications, doses and how often taken or attach a list to this form:**

_____ _____

_____ _____

_____ _____

Pharmacy Name: _____ Phone #: _____

**Please list all allergies:**

_____

_____

**Health Habits:**

| | | | | |
|---|---|---|---|---|
| Tobacco | ___ Yes | ___ No | How much? | _____ |
| Alcohol | ___ Yes | ___ No | How much? | _____ |
| Caffeine | ___ Yes | ___ No | How much? | _____ |
| Recreational Drugs | ___ Yes | ___ No | How often? | _____ |
| Exercise | ___ Yes | ___ No | What type? | _____ |

**Work History (Please complete if injured at work.)**

Current Employer: _____ Job Title: _____ Date of Hire: _____

Job Duties: _____

Level of Education Completed: ___ High School ___ College ___ Trade School ___ Other

Check if your work requires:
___ Lifting _____ lbs. ___ Pushing/Pull _____ lbs. ___ Vibration ___ Bending
___Repetitive Movements ___ Constant Sitting/Standing ___ Awkward Position ___ Reaching

Are you receiving income?: ___ Worker's Compensation ___ Disability and/or Social Security

Are you still working?: ___ Yes ___ Full Duty ___Modified Duty
___ No Last Day Worked _____
Do you like your job?: ___ Yes ___ No Do you have a second job?: ___ Yes ___ No
Is there a lawsuit?: ___ Pending ___ Settled ___ None

I authorize release of my medical records to all clinicians involved in my care. Listed are the names and addresses of any other party who should receive my records: _____
_____

***My attorney (if any) will need to write and send paper authorization to obtain my records.**

To the best of my knowledge all of the preceding answers are correct. If I have any changes in my health status, or if my medications change, I shall inform Morganstein De Falcis Rehabilitation Institute at my next appointment.

**Signature:** _____ **Date:** _____/_____/_____ **Updated:** _____/_____/_____

**Provider Signature:** _____ **Date:** _____/_____/_____