



MEDICAL HISTORY

1. How would you describe your overall health? Circle one

Excellent Good Fair Poor

2. Place a check mark next to any item that applies to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Difficulty hearing |
| <input type="checkbox"/> Difficulty with vision | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Frequent falls | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Fractures, where? _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Other: _____ | |

3. List any previous surgeries (type and approximate date):

4. List any allergies you have, including medications:

Completed by _____

Reviewed by/Date _____

REHAB MEDICAL HISTORY / MEDICATION FORM

PT OT ST

FORM #17272 02/2004



2PTASSM

