MENORAH MEDICAL CENTER

Outpatient Medical History Information/Patient Problem List

Date: _____

Name: _____
Last Middle Initial First

Referring Physician: _____ Primary Physician: _____

Hospitalizations: (include surgeries, fractures, or any other pertinent medical information)

_____

_____

_____

Allergies: _____

Current Medications: (include anti-inflammatory, pain, and muscle relaxants)

_____

_____

Have you had, or are you currently receiving home health care? (explain): _____

_____

Has anyone kicked, hit, or tried to control you and/or do you perceive that you are being hurt or threatened by anyone?

☐Yes ☐No _____

Have you had any falls in the past 12 months? ☐Yes ☐No _____

Have you or will you be receiving any of the following tests as a result of this condition? (Circle all that apply)

☐X-Ray ☐EMG ☐MRI ☐CT Scan ☐Dopler-Study ☐Other: _____

Results of Tests: _____

Personal History (Current "C" or Past "P" – please specify):

☐ High Blood Pressure	☐ Cancer/Tumor	☐ Frequent Swelling
☐ Low Blood Pressure	☐ Arthritis	☐ Tuberculosis
☐ Angina	☐ Broken Bones	☐ Hepatitis
☐ Pacemaker	☐ Thin Bones	☐ Paralysis
☐ Poor Circulation	☐ Head Injury	☐ Lung Problems
☐ Phlebitis	☐ Metal Implants	☐ Other_____
☐ Stroke	☐ Seizures/Convulsions	_____
☐ Rheumatic Fever	☐ Frequent Diarrhea	
☐ Diabetes	☐ Frequent Nausea	Date of Next Doctor Visit:
☐ Frequent Fainting	☐ Poor Eyesight	_____
☐ Frequent Depression	☐ Poor Hearing	Any possibility of pregnancy?
☐ Frequent Light-Headedness	☐ Kidney Problems	Yes____ No____

1) Chief complaint which brings you to Rehabilitation Services? _____

_____

_____

2) Please give goal of rehabilitation treatment. (Outcome of therapy) _____

_____

3) Is this visit the result of an injury/accident? If so, please explain how and where injury occurred: _____

_____

_____

4) Was this injury work related: ☐Yes ☐No Date of injury/accident: _____

5) Current Work Status: ☐Full Time ☐Full time with restrictions ☐Part time ☐Part time with restrictions
☐Off Work ☐Retired ☐Other_____

6) What are the top (2) tasks you are unable to perform as a result of your current condition (be specific)

1_____

2_____

_____
Patient Signature

Office Use Only: Referrals faxed to:_____ Fax #:_____

Patient Information Label