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