REVOLUTION REHABILITATION, P.C.

PATIENT MEDICAL HISTORY FORM

Name:_____ Age:_____ Height/Weight:_____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY: (Please put a check next to any condition that you have, and N/A next to those that you do not)

	High\Low Blood Pressure		Bowel or Bladder Problems		Asthma
	Abnormal Bleeding		Recent and sudden Weight Loss/Gain		Arthritis
	Heart Problem		Thyroid problems (Hyper or Hypo)		Emphysema
	Hearing problems		Diabetes(medication dependent **Yes** or **No**)		Dizziness
	High Cholesterol		Chronic heartburn/Intestinal upset		Night sweats
	Autoimmune disorder		Alcoholism\Chemical dependency		Pacemaker
	Headache\ Migraines		Cancer/tumors (where? _____)		Chest pain
	Seizures/Epilepsy		Chronic Lung Problem		Ulcers
	Shortness of breath		Stroke\ Head\Brain Injury		Hernia
	Kidney Disease		Cataracts\ Glaucoma\ Macular degeneration		Blood clots

Do you have any history of Hepatitis? (please circle your answer) A B C NONE
Do you have any known disease or infection that can be transmitted through bodily fluids? YES NO
Are you currently taking ANY form of blood thinners (this includes ibuprofen) YES NO

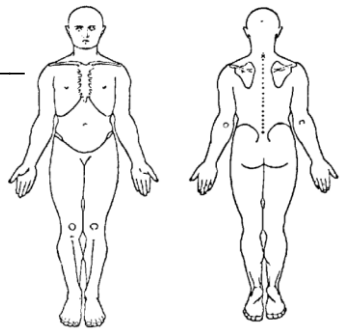
Do you have a history of fractures? Where? _____
Do you have a history of back/neck pain? When? _____
Do you smoke? How much per day? _____
Do you exercise regularly? How often? _____
Do you have any known allergies? Please list _____
Are you pregnant or suspect pregnancy? YES NO
Do you feel safe at home? Are you being physically or mentally abused? _____

MEDICATIONS: ***Please list medications or we can photocopy your list for you.***

_____
_____

SURGERIES: ***Please list all surgeries, including date:***

DIAGNOSTIC TESTS: Please check test(s) for current problem only.
( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density
( )Blood Chemistry ( )Ultrasound ( )Other (please specify)_____



SYMPTOMS: In regards to your current condition:
When did your symptoms begin? _____
Do you have any "pins and needles" or numbness in your extremities? YES NO
Do you have any weakness in your arms or legs? YES NO
Do you have any coordination or balance problems? YES NO
Do you have difficulty walking? YES NO
Have you experienced headaches as a result of your condition? YES NO
Have you had this problem before? YES NO
CHIEF COMPLAINT/ CURRENT CONDITIONS: Please describe: _____
_____

Please rate your pain in this scale of 0-10. *0=No Pain to 10=The Worst Pain You Can Imagine*
0 1 2 3 4 5 6 7 8 9 10
I believe all information to be true and complete:

Signature:_____**Date:**_____