Sandhills Rehabilitation & Wellness Center, Inc.

Patient Medical History

Patient:______________________ **Date:____________________** **Chart #:______________**

Referring Physician:____________________

I. Please check all of the following signs/symptoms that you have ever experienced.

	YES	NO		YES	NO		YES	NO
Weight Loss	____	____	Vision	____	____	High Blood Pressure	____	____
Fever, chills	____	____	Hearing	____	____	Leg swelling	____	____
Appetite change	____	____	Skin rashes/			Low Blood Pressure	____	____
Joint Pain	____	____	bed sore	____	____	Chest pain	____	____
Muscle Pain	____	____	Pneumonia	____	____	Fainting spells	____	____
Gout	____	____	Fatigue	____	____	Shortness of breath	____	____
Headaches	____	____	Nausea	____	____	Asthma	____	____
Redness/swelling	____	____	Vomiting	____	____	Cough	____	____
of a joint			Diarrhea	____	____	Memory loss	____	____
Frequent falls	____	____						
Seizures	____	____	Frequent	____	____	Kidney stones	____	____
Stroke	____	____	urination			Anemia	____	____
Numbness	____	____	Shingles	____	____	Blood clots	____	____
Kidney Disease	____	____	Anxiety	____	____	Seasonal Allergies	____	____
Hepatitis	____	____	TB	____	____	Hallucinations	____	____
HIV	____	____	Diabetes	____	____	Depression	____	____
Thyroid Disease	____	____				Heart Murmur	____	____

Primary Care Physician:________________________ **Referring Dr.:__________________________**

II. Past Medical History

Have you ever had or do you have any:

Illnesses:____

Drug Allergies:____

Operations:____

____

List Current Medications:____

____

____

III. Social History

Occupation:____

Tobacco? YES NO Packs/day___________________ Number of years used_____________

Alcohol? YES NO Amount___________________ Type of alcohol___________________

Illicit drug/substance use? YES NO Type of drug(s)____________________________________

IV. Family History

Does anyone in your immediate family (mother, father, siblings, children) suffer from any of the following? (Please check and identify which family member)

Heart Disease:_______________ Cancer (type):_____________ Diabetes:__________________

Lung Disease:_______________ Stroke:__________________ Tuberculosis:_______________

Alzheimer's:________________ Scoliosis:________________ Parkinson's:________________

Arthritis:___________________ Seizures:_________________ Multiple Sclerosis:___________

Patient Signature:_________________________________ **Date:____________________**

All items on this page were reviewed by______________(Therapist initials) on___________(date).