SRWC
Sandhills Rehabilitation & Wellness Center
people helping people

Patient Medical History

Patient Name (Last, First, MI): _____ **Date:** _____

Do you have a pacemaker? Yes____ No____ Do you smoke? Yes____ No____ Pack/day_____

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? **Yes____ No____**

Please check all of the following signs/symptoms that you <u>RECENTLY</u> experienced.

____ Fatigue
____Fever/chills/sweats
____Nausea/vomiting
____Weight loss/gain
____Difficulty Maintaining balance while walking
____Falls
____Numbness or tingling
____Muscle weakness
____Dizziness/lightheadedness
____Heartburn/indigestion
____Difficulty swallowing
____Changes in bowel or bladder function
____Seizures
____Constipation
____Diarrhea
____Shortness of breath
____Fainting
____Cough
____Headaches

Past Medical History

Have you ever had or do you have any:
Illnesses: _____
Drug Allergies: _____
Surgeries/Injuries/Hospitalizations: _____
_____
List Current Medications: _____
_____
_____

Family History

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

Heart Disease: _____
Lung Disease: _____
Alzheimer's: _____
Arthritis: _____
Cancer (type):_____
Stroke: _____
Scoliosis: _____
Seizures: _____
Diabetes: _____
Tuberculosis: _____
Parkinson's:_____
Multiple Sclerosis: _____

Patient Signature: _____ **Date:** _____

All items on this page were reviewed by_____ PT initials) **on**_____(date).