Medical History Summary List

Name:______________________________ Age:__________ Date:_____/_____/_____

At the present time, would you say your health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

If the beneficiary is unable to respond, indicate why:

____

____

Medical History

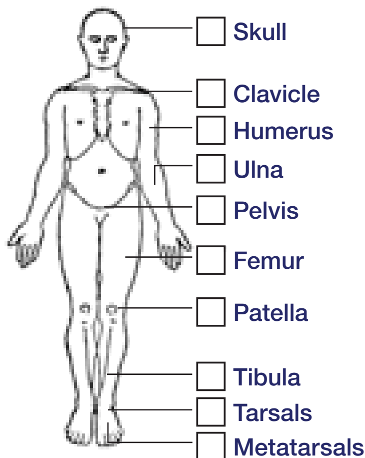
(Please Check If Yes)

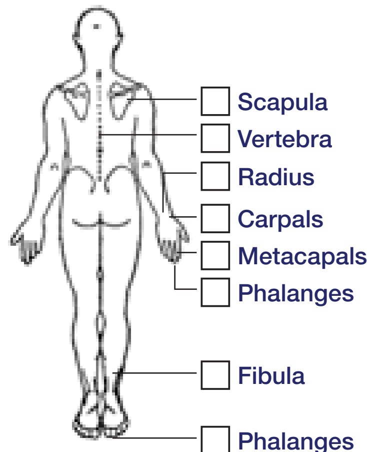
☐ Heart Disease
☐ Pacemaker
☐ High Blood Pressure
☐ Diabetes
☐ Stroke / TIAs
☐ Cancer
☐ Parkinson's
☐ Arthritis
☐ Scoliosis
☐ Osteoporosis
☐ Fibromyalgia
☐ Asthma
☐ Tuberculosis
☐ Pneumonia

☐ Epilepsy
☐ Hepatitis
☐ HIV /AIDS
☐ Falls
☐ Reflux
☐ Hearing Impaired
☐ Visually Impaired
☐ Pregnant

Allergies (check all that apply):

☐ Latex (rubber glove material)
☐ Avocado ☐ Banana
☐ Kiwi ☐ Tomato
☐ Other:____________________
____





Please check the location pictured above and state the current symptoms or problems below. (i.e. pain, numbness, weakness)

Symptoms:______________________________

Other Medical History:

____

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____

____

____

Surgical History (include dates):

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____

____

Current Medications:

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____

Currently receiving any home health services?

☐ No ☐ Yes

If yes, what services?

____

____

To the best of my knowledge and belief the information I have given is complete and true. I hearby give my consent to receive therapy services at Warm Springs Rehabilitation Centers.

____

Patient Signature

____

Therapist Signature

Date____________________Time______________