TOTAL HEALTH & REHABILITATION, INC.

Past Medical History

Patient Name:_____
Please Print

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Broken Bones /Fractures	____*Yes*	____*No*	***Seizures /Epilepsy***	____*Yes*	____*No*
Osteoporosis	____*Yes*	____*No*	***Stroke / CVA***	____*Yes*	____*No*
Arthritis	____*Yes*	____*No*	***Headaches***	____*Yes*	____*No*
Joint Replacement	____*Yes*	____*No*	***Head Injury***	____*Yes*	____*No*
Difficulty Walking	____*Yes*	____*No*	***Multiple Sclerosis***	____*Yes*	____*No*
High/Low blood pressure	____*Yes*	____*No*	***Parkinson Disease***	____*Yes*	____*No*
Irregular Heart Rate	____*Yes*	____*No*	***Muscular dystrophy***	____*Yes*	____*No*
Pacemaker	____*Yes*	____*No*	***Vertigo***	____*Yes*	____*No*
Bypass	____*Yes*	____*No*	***Diabetes***	____*Yes*	____*No*
Heart Problems	____*Yes*	____*No*	***Cancer***	____*Yes*	____*No*
Lung Problems	____*Yes*	____*No*	***Allergies***	____*Yes*	____*No*
Emphysema	____*Yes*	____*No*	***Hepatitis***	____*Yes*	____*No*
COPD	____*Yes*	____*No*	***HIV / AIDS***	____*Yes*	____*No*
Tuberculosis	____*Yes*	____*No*	***Any other Disease***	____*Yes*	____*No*
Unexpected Weight Loss in the last 3 Months	____*Yes*	____*No*	***Falls in last 3 mnths***	____*Yes*	____*No*
			Night Pain	____*Yes*	____*No*

SURGERIES: if answered ***YES*** please date

Spine	____*Yes*	____*No*	*Date:*_____
Joint Replacement	____*Yes*	____*No*	*Date:*_____
Brain	____*Yes*	____*No*	*Date:*_____
Thyroid	____*Yes*	____*No*	*Date:*_____
Heart	____*Yes*	____*No*	*Date:*_____
Bowel	____*Yes*	____*No*	*Date:*_____
Kidney	____*Yes*	____*No*	*Date:*_____
Gall Bladder	____*Yes*	____*No*	*Date:*_____
Appendectomy	____*Yes*	____*No*	*Date:*_____
Prostrate	____*Yes*	____*No*	*Date:*_____
Hernia	____*Yes*	____*No*	*Date:*_____
Hysterectomy	____*Yes*	____*No*	*Date:*_____
Stent	____*Yes*	____*No*	*Date:*_____

Other:_____
_____

I understand this is a questionnaire of my past medical history and health status. I certify that all above information is true and correct to the best of my knowledge.

Patient Signature:_____ ***Date***:_____/_____/_____