Hawaiian Rehabilitation Services, Inc.
Patient Medical History

Name:_____ Date:_____

* To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you!

Date of Birth:_____ Age:_____Height:_____ Weight:_____

Leisure Activities:_____

Are you pregnant? Y/N Estimated due date: _____

Have you recently noted any of the following: (Please check all that apply)

___ Weight Loss/Weight Gain ___Weakness
___ Nausea/Vomiting ___Fever/Chills/sweats
___Fatigue ___Numbness or Tingling

*Are you currently seeing any of the following? Please check all that apply.

___ Medical Doctor (M.D) ___Psychiatrist/Psychologist
___ Osteopath ___Physical Therapist/Occupational Therapist
___ Dentist ___Chiropractor
___Other:_____

*Have you EVER been diagnosed as having any of the following conditions? Please check all that apply.

___ Cancer. If yes describe what kind: _____

___ Heart problems	___ Epilepsy	___ Tuberculosis
___ Circulation problems	___ HIV	___ Hepatitis
___ High blood pressure	___ Asthma	___ Other arthritic conditions
___ Emphysema/Bronchitis	___ Chemical dependency (i.e. Alcoholism)	
___ Thyroid problems	___ Anemia	___ Depression
___ Diabetes	___ Kidney disease	_____ Other
___ Rheumatoid arthritis	___ Stroke	

___ Current infections: _____ Immunosuppression: _____

___ Progressive neurological deficits (e.g. MS, ALS): _____

*Has anyone in your immediate family (Parents, brothers, sisters) ever been treated for any of the following? (Please check all that apply)

___ Diabetes	___ Cancer	___ Alcoholism (Chemical Dependency
___ Tuberculosis	___ Arthritis	___ Mental illness
___ Heart disease	___ Anemia	___ Epilepsy
___ High blood pressure	___ Headaches	___ Kidney disease

*Are you currently taking any over the counter medications Y/N? Please list below. Are your also taking any prescription medication including (pills,injections,and/or skin patches) Y/N? Please list below.

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized for, including the approximate date and reason for the surgery or hospitalization:

Date:	Surgery/Hospitalization:	Reason:
_____	_____	_____

Please describe any injuries for which you have been treated for, (Including fractures, dislocations, sprains) and the approximate date of injury:

Date:	Injury:	Date:	Injury:
_____	_____	_____	_____

- How much caffeinated coffee or caffeine containing beverages Do you drink per Day? _____
- How Many packs of cigarettes do you smoke per day? _____
- How many days per week do you drink alcohol? _____
- If one drink equals one beer/glass or wine, how much do you drink in one average sitting? _____
- How many days per week do you use marijuana? _____
- How many days per week do you use drugs such as cocaine, crack, acid, etc? _____

_____

For Office Use: Form Reviewed with patient: ___Yes ___No Therapist Signature: _____ Date:_____2/15AS

Revised 6/11 JT/cp