Date: _____ **Time:** _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PATIENT'S PRIMARY LANGUAGE: _____

PREFERRED LANGUAGE FOR DISCUSSING HEALTHCARE: _____

PERSONAL MEDICAL HISTORY – PLEASE CHECK ALL THAT YOU HAVE EVER HAD

☐ Arthritis	☐ Pneumonia	☐ Seizures/epilepsy*	☐ Ulcers/stomach problems
☐ Broken bones/fractures	☐ Diabetes/high blood sugar	☐ Allergies	☐ Mitral Valve Prolapse
☐ Osteoporosis	☐ Low blood sugar/ hypoglycemia	☐ Developmental or growth problems	☐ Acid reflux
☐ Blood Disorders	☐ Kidney problems	☐ Thyroid problems	☐ Skin diseases
☐ Circulation/vascular problems	☐ Head injury	☐ Cancer Type: _____	☐ Depression
☐ Heart Problems	☐ Multiple sclerosis	☐ Infectious disease (e.g., tuberculosis, hepatitis)	☐ Fatigue
☐ High blood pressure	☐ Muscular dystrophy	☐ Stroke	☐ Other: _____
☐ Lung/respiratory problems	☐ Parkinson's disease	☐ Repeated infections	_____

WITHIN THE PAST YEAR, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

☐ Chest pain	☐ Weakness in arms or legs*	☐ Difficulty sleeping	☐ Urinary problems
☐ Heart palpitations	☐ Loss of balance*	☐ Loss of appetite	☐ Fever/chills/sweats
☐ Cough	☐ Difficulty walking*	☐ Nausea	☐ Headaches
☐ Hoarseness	☐ Hearing problems*	☐ Vomiting	☐ Joint pain or swelling
☐ Voice problems	☐ Vision problems*	☐ Difficulty swallowing	☐ Pain at night
☐ Shortness of breath	☐ Hemorrhoids	☐ Bowel problems	☐ Falls
☐ Dizziness or blackouts*	☐ Liver Disease	☐ Weight loss/gain	☐ Other: _____
☐ Coordination problems*			_____

**indicates fall risk*

DO YOU HAVE A PACEMAKER? ☐ Yes ☐ No

HAVE YOU EVER HAD SURGERY? ☐ Yes ☐ No **If yes, please describe and include dates:**	**Month**	**Year**

FOR MEN ONLY: HAVE YOU BEEN DIAGNOSED WITH PROSTATE DISEASE? ☐ Yes ☐ No

FOR WOMEN ONLY: HAVE YOU BEEN DIAGNOSED WITH:

☐ Pelvic inflammatory disease ☐ Endometriosis ☐ Complicated pregnancies or deliveries

☐ Osteoporosis ☐ Trouble with your period ☐ Pregnant or think you might be pregnant

☐ Other gynecological or obstetrical difficulties: _____

BAPTIST Rehabilitation

Jacksonville, FL

PATIENT MEDICAL HISTORY FORM

4820

PATIENT LABEL

CURRENT CONDITION(S)/CHIEF COMPLAINT(S)
Describe the problem(s) for which you seek therapy:

When did the problem(s) begin:	Month	Year
How are you taking care of the problem(s) now?		
What makes the problem(s) better?		
What makes the problem(s) worse?		
What are your goals for therapy?		

HAVE YOU EVER HAD THE PROBLEM(S) BEFORE? ☐ Yes ☐ No

If so, what did you do for the problem(s)?

Did the problem(s) get better? ☐ Yes ☐ No

About how long did the problem(s) last?

ARE YOU SEEING ANYONE ELSE FOR THE PROBLEM(S)?

☐ Acupuncturist ☐ Cardiologist ☐ Chiropractor ☐ Dentist
☐ Gastrointestinal Physician ☐ Internist ☐ Massage Therapist ☐ Orthopedist
☐ Pediatrician ☐ Physical Therapist ☐ Podiatrist ☐ Primary Care Physician
☐ Pulmonologist ☐ Rheumatologist ☐ Speech Language Pathologist
☐ Occupational Therapist ☐ Osteopath ☐ Family Practitioner
☐ Other Specialist: _____

DO YOU TAKE ANY PRESCRIPTION MEDICATIONS? ☐ Yes ☐ No If yes, please list below:

NAME OF MEDICATION	DOSE	HOW FREQUENTLY	LAST DOSE TAKEN

DO YOU TAKE ANY NON-PRESCRIPTION MEDICATIONS? ☐ Yes ☐ No If yes, please check all that apply:

☐ Antacids ☐ Aleve/Naproxen ☐ Advil/Ibuprofen	☐ Antihistamines ☐ Aspirin	☐ Herbal supplements ☐ Tylenol	☐ Other: _____ ☐ Other: _____

DO YOU HAVE ANY KNOWN DRUG OR FOOD ALLERGIES? ☐ Yes ☐ No If yes, please list below:

NAME OF ALLERGEN	REACTION	DATE OF ONSET IF KNOWN	DATE OF LAST REACTION

Within the past year, have you had any of the following tests? ☐ Yes ☐ No If yes, please check all that apply:

☐ Angiogram	☐ Doppler ultrasound	☐ MRI	☐ Stress test (e.g., treadmill)
☐ Arthroscopy	☐ Echocardiogram	☐ Myelogram	☐ Urine tests
☐ Biopsy	☐ EEG (electroencephalogram)	☐ NCV (Nerve Conduction Velocity)	☐ X-rays
☐ Blood tests	☐ EKG (electrocardiogram)	☐ Pap smear	☐ MBS (Modified Barium Swallow)
☐ Bone	☐ EMG (electromyogram)	☐ Pulmonary function test	☐ EGD/Upper GI Exam
☐ Bronchoscopy	☐ Esophagram	☐ Spinal tap	☐ Other: _____
☐ CT scan	☐ Mammogram	☐ Stool tests	

FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply)

Do you have difficulty with:	Do you have difficulty walking on:	Do you use an assistive device with walking?	Have you fallen within the last 3 months?
☐ Bed mobility ☐ Transfers (such as moving from bed to chair to sit, to stand)	☐ Level ground ☐ Stairs ☐ Ramps ☐ Uneven terrain	☐ Yes ☐ No ☐ If yes, please list: _____	☐ Yes ☐ No ☐ If yes, please describe: _____

Do you have difficulty with self-care (such as bathing, dressing, toileting)? ☐ Yes ☐ No
Do you have difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)? ☐ Yes ☐ No
Do you have difficulty with community and work activities? ☐ Yes ☐ No
(at work/school, recreation or play activity)
Do you have difficulty with swallowing or eating? ☐ Yes ☐ No
Do you have difficulty with talking, listening, reading or writing? ☐ Yes ☐ No

HEALTH HABITS/EXERCISE

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No

If yes, describe the exercise: _____
On average, how many days per week do you exercise or do physical activity? _____
For how many minutes, on an average day? _____

Do you smoke or use other tobacco products? ☐ Yes ☐ No
If yes, how much and how often? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much and how often? _____

At Baptist Health we are concerned about the safety of our patients and their caregivers. Help is available for people in our community affected by domestic violence/abuse, neglect, exploitation, and/or mental health illness.		
Have you been emotionally or physically abused?	☐ Yes	☐ No
If yes, are you still at risk?	☐ Yes	☐ No
If yes, would you like some information about services available in this community?	☐ Yes	☐ No
Over the past 2 weeks, have you felt down, depressed, or hopeless?	☐ Yes	☐ No
Over the past 2 weeks, have you had any thoughts of hurting yourself or others?	☐ Yes	☐ No
If yes, would you like some information about services available in this community?	☐ Yes	☐ No

Printed Name	Signature	Date	Time