Milford Regional Medical Center
Outpatient Rehabilitation & Sports Medicine
Patient Information Record/History Form

Patient's Name: **Today's Date:**
Home Phone #: **Cell Phone #:**

Occupation: ☐ Full-time ☐ Part-time ☐ Retired
Date of Injury/Problem: **Current Injury/Problem:**

Do you have any allergies? ☐ Yes ☐ No, Please list: ______

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No
If Yes, list medications and reason for taking:

______ ______ ______
______ ______ ______
______ ______ ______
______ ______ ______

Major surgical procedure within the last 60 days (e.g., craniotomy, laminectomy)? ☐ Yes ☐ No

List Prior Surgeries/Hospitalizations Dates:

______ ______ ______
______ ______ ______

Emergency Contact: ______ Relationship: ______ Home Phone:______
Work Phone: ______ Cellular Phone/Beeper: ______

Which of the following treatments/test have you undergone for your current problem?
☐ X-Rays ☐ MRI ☐ Other: ______

Do you now have or have you ever had ANY of the following?

YES	NO		YES	NO	
		Asthma, Bronchitis, or Emphysema/Shortness of Breath			Pain at Night
		Congestive Heart Failure			Severe or Frequent Headaches
		Coronary Heart Disease/Angina/Chest Pain			Vision/Hearing Difficulties
		Do you have a pacemaker/internal defibrillator?			Numbness or Tingling
		High Blood Pressure			Dizziness or Fainting
		Stroke/TIA			Weight Loss/Energy Loss
		Blood Clot/Emboli			Nausea/Vomiting
		Epilepsy/Seizures			Circulation Difficulties
		Neurological Disorders			Diabetes
		Cancer (skin or otherwise; specify) ______			Any Pins/Metal Implants?
		Chemotherapy/Radiation			Joint Replacement
		Family History of Cancer (specify) ______			Gout
		Infectious Disease (specify) ______			Hepatitis
		Arthritis/Swollen Joints			Lung Disease
		Osteoporosis			Tuberculosis
		History of Falls			Liver Disease
		Sleeping Difficulties			Are You Pregnant?
		Emotional/Psychological Difficulties			Do You Smoke?
		Bowel/Bladder Problems			Lupus/Fibromyalgia
		Swallowing Difficulties			Specify Other:______

Do you have any religious or cultural practices that may affect your care?______

List any other information that would assist us in your care: ______

Please specify your expectations/goals while in this program: ______

☐ Patient/caregiver unable to complete form; information reviewed and completed by therapist. ______
Initials

______ ______
Patient Signature (or guardian, if under 18 yrs old): Date

______ ______
Clinical Signature/Title/Initials Date