CENTER FOR PHYSICAL MEDICINE & REHABILITATION HEALTH HISTORY FORM

PATIENT NAME:	DOB:
PRIMARY CARE PHYSICIAN: None recorded.	PHONE:
CURRENT PHARMACY:	PHONE:

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? *Please describe in short detail the reason for your visit and the onset of symptoms:

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Please Answer the following questions:

Do you smoke? YES or NO *If you answered yes, how much?___________

Do you drink alcohol? YES or NO *If you answered yes, how much?___________

On a scale of 0-10 (0 being no pain & 10 being the worst, what is your current pain level? ________

TREATMENTS TRIED *PHYSICAL THERAPY, TENS UNIT, ACCUPUNCTURE, INJECTIONS, MEDICATION ETC

TREATMENT	FACILITY	DATE

DIAGNOSTIC TESTING *MRI, CT, EMG, XRAYS, ETC.

TEST	FACILITY	DATE

FAMILY HISTORY *DIABETES, CANCER, HEART DISEASE, ETC.

FAMILY MEMBER	ILLNESS	AGE	ALIVE	DECEASED

CURRENT and PAST MEDICATIONS

MEDICATION NAME	DOSAGE	FREQ.	PHYSICIAN	START	END DATE	PURPOSE

SURGICAL PROCEDURES

PROCEDURE	PHYSICIAN	HOSPITAL/FACILITY	DATE