Rehab Partners, Inc.
Health History Questionnaire Date_____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name: _____ DOB: _____ Age: _____

What medical concerns bring you to our office? _____

If disabled, check here: ☐ Nature of disability: _____

Do you exercise routinely? *(circle)* Yes No If yes, what exercise/how often? _____

Have you used tobacco products one or more times within the last 24 months? (circle) Yes No
If yes, was cessation counseling intervention received? (circle) Yes No

Have you completed Advanced Directives or do you have a Living Will? *(circle)* Yes No Which? _____

Tell us about your home environment: *(e.g. live alone or with family; house or apt; stairs? pets?)*

_____

Have you had 2 or more falls in the past year, or any one fall with injury in the past year? (circle) Yes No

Medical Information:

Allergies: _____

Have you ever been diagnosed with or treated for the following conditions? Check all that apply:

☐ Pacemaker	☐ Heart Attack	☐ High Blood Pressure	☐ Diabetes	☐ Stroke/TIA
☐ High Cholesterol	☐ Osteoporosis	☐ Rheumatoid Disease	☐ Osteoarthritis	☐ Seizures
☐ Asthma	☐ COPD	☐ TB/Lung Disease	☐ Pneumonia	☐ Anemia
☐ Thyroid Disease	☐ Lupus	☐ Multiple Sclerosis	☐ Fibromyalgia	☐ HIV/AIDS
☐ Liver Disease	☐ Kidney Disease	☐ Hepatitis A, B or C	☐ Digestive Disorder	
☐ Depression	☐ Anxiety	☐ Glaucoma	☐ Cataracts	

☐ Cancer (please specify type and year diagnosed):_____

	Dosage	Frequency	Route of Administration
Prescription Medications:			
Over-the-counter Medications:			
Herbal medications:			
Vitamins/Minerals/Dietary (nutritional) supplements:			

Please list all illnesses, medical conditions and surgeries not discussed above:

_____

_____

_____

Personal Safety: (circle your answer)

Are you under a lot of pressure at work or home? Yes No If yes, which? _____

Do you have any safety concerns? Yes No

Do you have any difficulty obtaining or preparing 2 meals per day? Yes No

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I certify that I have read and understand the above. I will not hold Rehab Partners, Inc. or any of its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient's/Guardian's signature (or individual completing form for patient) Date