 **Next Level Rehabilitation**

 108 Plant Avenue Wayne, PA 19087 P: 610.389.4845 F: 484.580.2141

 Medical History Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_

*Do you have a history of any of the following*?

High Blood Pressure Y N Arthritis Y N Kidney Disease Y N

Angina/Chest Pain Y N Hepatitis/HIV Y N Liver Disease Y N

Heart Disease Y N Seizures Y N Thyroid Problem Y N

Stroke Y N Headaches Y N Urinary Issues Y N

Diabetes Y N Depression Y N Gastrointestinal Y N

Osteoprosis Y N COPD Y N Hearing Difficulties Y N

Cancer Y N Asthma Y N Vision Difficulties Y N

If answered ‘Yes,’ please provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*In the past 3 months, have you experienced any of the following*?

Hospitalization Y N Change in bowel or bladder Y N Nausea/Vomiting Y N

Shortness of breath Y N Unexplained weight change Y N Numbness/Tingling Y N

Dizziness Y N Upper respiratory infection Y N Fever/Chills/Sweats Y N

If answered “Yes,” Please provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Quick Screen*

Pregnant or planning to become pregnant? Y N Do you smoke or use tobacco products? Y N

Have you fallen 2 or more times in the past year? Y N If so, any injuries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Medications:* Please list any medications, supplements, or vitamins that you take regularly.

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*Surgeries*: (Please list and date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*On the image below, please use the indicated symbols to mark the location and nature of your symptoms*

SHARP PAIN ACHINESS BURNING PINS & NEEDLES NUMBNESS

///// XXXXX !!!!!! 00000 +++++

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*Please record symptoms below for all locations involved:*

(Example: Neck 4-5/10, Back 6-7/10, Right leg 2-3/10)

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Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_