Rehabilitation Associates of Naples

Comprehensive Rehabilitation Services...to help meet life's challenges

Patient Medical History

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Allergies

_____

_____

_____

_____

Medical History/Hospitalizations

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

Assistance

Do you require assistance with:

1. Dressing? Yes ____ No ____
2. Bathing? Yes ____ No ____
3. Toileting? Yes ____ No ____
4. Meals? Yes ____ No ____

Do you ever use:

1. Cane? Yes ____ No ____
2. Walker? Yes ____ No ____
3. Wheelchair? Yes ____ No ____

Social History

Lives with _____

How many levels is your home? _____

Stairs to enter? _____

If condo, what level _____

Marital Status M___ W___ S___ D___

Do you or any Blood Relative have a history of :

Problem	Self	Year	Who
Alcoholism			
Allergies			
Anemia			
Arthritis			
Asthma			
Bleeding			
Bowel Problems			
Cancer			
Chicken Pox			
Diabetes			
Emotional Problems			
Emphysema			
Epilepsy			
German Measles			
Glaucoma			
Heart Disease			
High Blood Pressure			
Hives			
Indigestion			
Influenza			
Kidney Disease			
Kidney Infections			
Leukemia			
Measles (10 day)			
Migraines			
Mumps			
Polio			
Rheumatic Fever			
Sexually Trans. Disease			
Skin Infections			
Stroke			
Stomach Problems			
Tuberculosis			

Habits - Be Honest!

Cups or glasses per day: Coffee ( ) Tea ( ) Cola ( )

Cigarettes per day _____

Alcohol or other substance: _____ amount _____

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