Rehabilitation Associates of Naples

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

Patient Medical History

Height: _____ Weight: _____

Medications

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

Allergies

_____
_____
_____
_____
_____
_____
_____

Medical History/Hospitalizations

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Therapy History

Are You Currently Receiving any type of Therapy: _____

Type: _____ Location: _____

Dates: _____

Home HealthCare

Are You Currently Enrolled in Home Health? _____

Date Started: _____ Date Ended: _____

Assistance

Do you require assistance with:		Do you ever use?	
1. Dressing	Yes ___ No ___	1. Cane?	Yes ___ No ___
2. Bathing	Yes ___ No ___	2. Walker?	Yes ___ No ___
3. Toileting	Yes ___ No ___	3. Wheelchair?	Yes ___ No ___
4. Meals	Yes ___ No ___		

Social History

Lives with: _____

Levels in Home: _____

Stairs to Enter: _____

In 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 Dis			
Skin Infections			
Stroke			
Stomach Problems			
Tuberculosis			

Habits - Be Honest

Cups or Glasses per Day: (___) Coffee (___) Team (___) Cola

Cigarettes per Day: _____

Alcohol or other substitute: _____ Amount: _____

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