P R O S P E C T

R e h a b i l i t a t i o n, PC

PATIENT REGISTRATION
MEDICAL HISTORY QUESTIONNAIRE

Prospect Rehabilitation, PC strives to provide exemplary care in the areas of injury treatment and prevention, health & fitness, and sports conditioning. To help us provide these services and to meet our legal obligations as a health care provider, please answer the questions on the following pages. Thank you.

PATIENT REGISTRATION:

Last Name_____First Name_____Middle Initial____

Mailing Address/City/State/Zip_____

Home Phone #_____Work Phone #_____Date of Birth (m/d/y)_____

Gender:	Marital Status:	Employment Status:	Student Status:
❑ Female	❑ Single	❑ Full Time	❑ Full Time
❑ Male	❑ Married/CU	❑ Part Time	❑ Part Time
		❑ Retired	
		❑ Not Employed	
		Employer Name:_____	

Primary Care Physician:_____Referring Physician:_____

EMERGENCY CONTACTS: Please list two people we could contact in case of an emergency.
Name: _____ Telephone: _____
Name: _____ Telephone: _____

Have you received any in-home medical services or been discharged from an in-patient facility within the past 30 days? __YES __NO
If YES, what organization provided this care, and what was your discharge date?_____

Have you received outpatient physical therapy or speech therapy at this or another location within the past year? ____YES ____NO
If YES, please list the diagnosis and provider: _____

In the past 12 months, have you had two or more falls or one fall that resulted in injury? _____YES _____NO

MEDICAL HISTORY

Do you have now, or have you had in the past:

	YES	NO		YES	NO
Heart-related Condition:	❑	❑	Stroke/TIA:	❑	❑
Chest Pain:	❑	❑	Tuberculosis:	❑	❑
Heart Murmur:	❑	❑	Cholesterol Over 240 mg/dl:	❑	❑
High Blood Pressure:	❑	❑	Phlebitis:	❑	❑
Joint Pain/Arthritis:	❑	❑	Ulcers:	❑	❑
Osteoporosis:	❑	❑	Thyroid Disease:	❑	❑
Anemia:	❑	❑	Anorexia/Bulimia:	❑	❑
HIV:	❑	❑	Hepatitis/Liver Disease:	❑	❑
Epilepsy:	❑	❑	Multiple Sclerosis:	❑	❑
Gout:	❑	❑	Cataracts/Glaucoma:	❑	❑
Nose Bleeds:	❑	❑	Blurred/Double Vision:	❑	❑
Ringing in Ears:	❑	❑	Dermatitis:	❑	❑
Fainting/Dizzy Spells:	❑	❑	Asthma/Lung Problems:	❑	❑
Cancer:	❑	❑	Seizures/Neurological Problems:	❑	❑
Diabetes:	❑	❑	Gallbladder/Intestinal Problems:	❑	❑
Back Problems:	❑	❑	Kidney Disease	❑	❑
Hernia:	❑	❑	Physician's Advice not to Exercise:	❑	❑

Alzheimer's, Dementia, Cognitive Deficits or status changes: YES ☐ NO ☐

Please list any past surgeries/accidents/hospitalizations/disease processes/orthopedic or other serious injuries:

_____

_____

How would you describe your current level of health? ❑excellent ❑very good ❑good ❑fair ❑poor

Do you have, or has your doctor ever told you that you have, a condition that could be aggravated or be made worse by exercise? YES ❑ NO ❑

Are you over age 65 **and also** not accustomed to vigorous exercise: YES ❑ NO ❑

Do you have a permanent disability rating? YES ❑ NO ❑ Area:_____ Date Rec'd:_____%____

Are you pregnant, lactating, anticipating becoming pregnant, or pregnant within the past year? YES ❑ NO ❑

Do you have a family history of heart disease in a parent or sibling before age 55: YES ❑ NO ❑

Have you ever been diagnosed with an infection such as HIV, MRSA, etc? YES ❒ NO ❒

Please list any allergies:_____

Do you smoke? YES ❑ NO ❑ If yes, # packs/day:____ If quit, year quit:____

I acknowledge that the above information is correct to the best of my knowledge.

Signature:_____ Printed Name:_____ Date:_____