Memorial HOSPITAL

Name: ____ **Date of Birth:** ________ **Date:**________

1. Cultural/ Religious: Any customs or religious beliefs or wishes that might affect your care?

____

2. Have you completed any of the following advance directives?

Do Not Resuscitate ◻ Yes ◻ No
Living Will ◻ Yes ◻ No

If yes, do you wish to provide us a copy of your advance directive? ◻ Yes ◻ No
Do you want a referral to learn more about advance directives? ◻ Yes ◻ No

3. Medical/ Surgical History:

a. Check if you have had or currently have:

◻ Pacemaker ◻ Head Injury ◻ Parkinson's Disease ◻ Arthritis: Rheumatoid or Osteoarthritis (circle)
◻ COPD ◻ Lung Problems ◻ High Blood Pressure ◻ Broken bones/ Fractures
◻ Diabetes ◻ Ear Infections ◻ Osteoporosis ◻ Seizures/ Epilepsy
◻ Stroke ◻ Heart Problems ◻ Cancer ◻ Infectious Disease (e.i., tuberculosis, hepatitis)
◻ Other:____

b. Have you had any of these symptoms within the last 6 months? (Check all that apply)

◻ Chest Pains ◻ Bowel or bladder control problems
◻ Dizziness or Blackouts ◻ Unexplained weight loss/ gain

c. Have you had surgeries in the past? ◻ Yes ◻ No If yes, please describe, and include dates:

Surgery	Month/ Year	Surgery	Month/ Year
____________________	/	____________________	/
____________________	/	____________________	/

For Women only: Are you pregnant, or think you might be pregnant? ◻ Yes ◻ No

4. Pain – Please rate your current and worst pain levels within the last 2 weeks on our scale of 0-10 (0 = no pain at all, 10 = is pain so bad you would go to the emergency room) **Currently____ Worst ____**

5. Please list your current Medications (or allow the secretary to get a copy if you have a list)**:**

6. Allergies: Check if you are allergic to the following: ◻ Latex ◻ Tape(s) ◻ Other:____________________

Signature ____Date: ______________

If filled out by someone other than the patient: Relationship to patient:______________________________

REHABILITATION SERVICES HEALTH HISTORY

Patient ID