Rehabilitation Institute of Wisconsin

Medical History Form

Please complete this form to the best of your knowledge. This information will help us serve you better.

Name: _____ **Leisure Activities:** _____

ALLERGIES: List any medication (s) you are allergic to: _____

Are you latex sensitive? Yes No List any other allergies we should know about _____

Have you **EVER** been diagnosed as having any of the following conditions?

Yes	No	Cancer. If **YES**, describe what kind: _____
Yes	No	Heart Problems
Yes	No	High blood pressure
Yes	No	Circulation problems
Yes	No	Asthma
Yes	No	Emphysema/Bronchitis
Yes	No	Chemical dependency (i.e., alcoholism)
Yes	No	Thyroid problems
Yes	No	Diabetes
Yes	No	Multiple sclerosis
Yes	No	Rheumatoid arthritis
Yes	No	Other arthritic conditions
Yes	No	Depression
Yes	No	Hepatitis
Yes	No	Tuberculosis
Yes	No	Stroke
Yes	No	Kidney disease
Yes	No	Anemia
Yes	No	Epilepsy
Yes	No	Other

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate year:

YEAR	REASON FOR SURGERY/HOSPITALIZATION	YEAR	REASON FOR SURGERY/HOSPITALIZATION

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY

Have you recently noted:

Yes	No	Weight loss/gain	Yes	No	Weakness
Yes	No	Nausea/vomiting	Yes	No	Fever/chills/sweats
Yes	No	Fatigue	Yes	No	Numbness or tingling

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Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches). Please include prescriptions, over-the-counters, herbals, and vitamin/mineral supplements:

MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

Patient Signature

Date

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