

# HC HIGHLAND CLINIC

DATE: \_\_\_\_\_  
 MD Seeing Today \_\_\_\_\_

**PHYSICAL MEDICINE  
 & REHABILITATION**  
 FAX TO 4451

PCP/REFERRING MD  
 \_\_\_\_\_

**PATIENT HISTORY FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**Past Medical History:**

*Do you have?*

- |  |  |
|--|--|
| <input type="checkbox"/> None            | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Lung Disease    | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Diabete         | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Gout                  |
| <input type="checkbox"/> Fibromyalgia    | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Other _____     |  |

**Ortho Surgery**

- Bone or Joint  
 Type: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Surgical History:**

*Have you had?*

- Thyroid  
 Appendectomy  
 Hysterectomy  
 Wisdom Teeth  
 Gallbladder  
 Tonsillectomy  
 Other \_\_\_\_\_  
 None

**Allergies:** \_\_\_\_\_  None

**Medications:** *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)*  None

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Family History:**

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Liver Disease  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Fibromyalgia   |
| <input type="checkbox"/> Other _____         | <input type="checkbox"/> None           |

**Social History:**

- Occupation: \_\_\_\_\_  
 Dominant Hand: R L  
 Tobacco Use Yes No  
 Alcohol Use Yes No  
 Height \_\_\_\_\_ Weight \_\_\_\_\_

**Review of Systems: *Do you have?***

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Skin Rash        | <input type="checkbox"/> Nausea/Vomiting     | <input type="checkbox"/> Painful Urination  |
| <input type="checkbox"/> Chills              | <input type="checkbox"/> Skin Lesion      | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Fever               | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Weight Gain         | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Depression          | <input type="checkbox"/>                    |
| <input type="checkbox"/> Weight loss         | <input type="checkbox"/> Reflux           | <input type="checkbox"/> Bruising            |   |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Blood in stool   | <input type="checkbox"/> Cough               |   |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Shortness of Breath |   |