RMA Clinic Health History

Name: ____ Check: ☐ Right ☐ Left Handed
(Please Print) Last First Middle Initial
Date of Birth: ________________ Age: _____________ Person Completing Form: ☐ Self ☐ Other

Reason for Visit: ____

Requested By: ________________________ Primary Care Physician: ____________________

PAST MEDICAL HISTORY

(Check those that apply and explain below.)

☐ High Blood Pressure
☐ Elevated Lipids/Cholesterol
☐ Diabetes
☐ Heart Disease
☐ Stroke
☐ Thyroid Disease
☐ Lung Problems
☐ Kidney Problems

☐ Seizures
☐ Alcohol/Chemical Dependency
☐ Migraine/Recurrent Headaches
☐ Arthritis/Joint Problems
☐ History Of Cancer (Describe)
☐ Ulcers/Gastritis/GERD
☐ Previous Work Injuries
☐ Nerve Disorder

☐ Stress Related Problems
☐ Depression
☐ Motor Vehicle Accidents
☐ Previous Fracture
☐ Deep Vein Thrombosis
☐ Hemorrhoids
☐ Prostate Problems
☐ Other

Explain any boxes checked:

SURGICAL HISTORY

Date	Surgery	Surgeon/Hospital

PLEASE LIST CURRENT MEDICATIONS

(Include injections, herbal medications, vitamins, over the counter medicines, etc.)

Medication	Dose	What do you use it for?	Used for how long?

Please List All Medication Allergies: ____

Other Allergies: ____

HABITS

Smoking/Chewing Tobacco

Have you ever smoked? ☐ Yes ☐ No ▪ Check those that apply: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew
Average Number of Packs Smoked Per Day: ____ ½ Pack Per Day ____1-2 PPD ____2-3 PPD
Age when you started? ______ Age when you quit smoking? ______

Caffeine

How many cups of coffee do you drink per day? _______
How many cups of other caffeinated beverage do you drink per day? ______

Alcohol

Do you ever drink alcohol: Yes ____ No ____ Average amount you drink per week: ______________
How many times in the past year have you had more than 4 drinks in a day __________
Have you ever used alcohol to control your pain? Yes ____ No ____
Were either of your parents alcoholics? Yes ___ No ___ If yes, Mother ____ Father ____ Both ____

Drugs

Now or in the past have you used drugs such as (please check all you have used):

☐ Stimulants ☐ Marijuana ☐ Heroin
☐ Sedatives ☐ Narcotics ☐ Cocaine
☐ Hallucinogens ☐ Anti-anxiety Agents ☐ Meth

When was the last time you used any of the above? _____________

FAMILY HISTORY

Family Diseases (Check those that apply and explain below):

☐ High Blood Pressure ☐ Migraine ☐ Parkinson's
☐ Diabetes ☐ Arthritis/Joint Problems ☐ Depression
☐ Carpal Tunnel Syndrome ☐ Spine Problems ☐ Alcoholism
☐ Heart/Vascular Disease ☐ Cancer ☐ Other Diseases _________
☐ Stroke ☐ Multiple Sclerosis _________________________
☐ Seizure ☐ Alzheimer's Disease

____
____
____

Father's Age: ____ Deceased? ____ Medical Problems? ____________________________________
Mother's Age: ____ Deceased? ____ Medical Problems? ____________________________________
Has anyone in your family been on disability? Yes ____ No ____
If yes, what is their relationship to you? ____

SOCIAL HISTORY

Birthplace: ________________________________ Native Language: __________________________
Have you been married? ☐ Yes ☐ No If yes, how many times? __________________________
Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Sex and Ages of Children: ____
Whom do you live with? ____
Have you ever considered yourself a victim of physical, emotional, or sexual abuse? ☐ Yes ☐ No
Are you in a relationship where you are being hurt or beaten? ☐ Yes ☐ No
Do you feel safe ☐ Yes ☐ No

WORK HISTORY

List Last Five (5) Years Of Employment and Include Any Military Service

Date (From – To)	Employer	Type of Work
______________________	________________________________	____________________
______________________	________________________________	____________________
______________________	________________________________	____________________
______________________	________________________________	____________________
______________________	________________________________	____________________

EDUCATION HISTORY

Please check the appropriate level:

____ I received a high school diploma
____ I received a GED
____ I did not complete high school or receive a GED

What is your highest level of educational training? ___________________________________

Any Other Comments?

____
____
____
____

Thank you for completing this form. Please sign and date below.

____	__________________________________
Signature	Date

Physician Signature __________________________Date__________________________

REHABILITATION MEDICINE ASSOCIATES, P.C.

REVIEW OF SYSTEMS Name: ________________________________ Date: ________

(Please Print Patient Name)

Please review the following symptoms and check the appropriate box if the symptom is **Absent** or **Present** at the time you complete the form. Please give a brief explanation of any symptoms that you indicate are currently present.

Symptoms		**Explanation**
Absent	***Present***	***CONSTITUTIONAL***
❑	❑	Weight change
❑	❑	Appetite change
❑	❑	Fevers
❑	❑	Night sweats
❑	❑	Back pain at night
❑	❑	Difficulty sleeping
❑	❑	Excessive tiredness
❑	❑	Generalized morning stiffness
❑	❑	___Anxious; ___ Irritable; ___Angry
❑	❑	Poor attention / concentration
❑	❑	Unusual stress: ___ at home; ___ at work
Absent	***Present***	***EYES / ENT***
❑	❑	Dry eyes / Red eyes
❑	❑	Nasal congestion
❑	❑	Dry mouth
❑	❑	Sore throat
Absent	***Present***	***RESPIRATORY (Breathing)***
❑	❑	Persistent cough
❑	❑	Cough up blood
❑	❑	Shortness of breath: ___at rest; ___with activity; ___when lying flat
❑	❑	Pain in chest with deep breath
Absent	***Present***	***CARDIOVASCULAR***
❑	❑	Chest pain / chest tightness: ___at rest; ___with activity
❑	❑	Swelling (edema) in legs / feet
❑	❑	Rapid heart beat (pulse) / palpitations
❑	❑	Easy bruising
Absent	***Present***	***GU / BLADDER / URINARY***
❑	❑	Difficulty starting urination
❑	❑	___Slow stream; ___ Dribbling after urination
❑	❑	Frequent urination: ___daytime; ___night
❑	❑	Blood in urine
❑	❑	Pain / burning with urination
❑	❑	Sexual dysfunction
Absent	***Present***	***GI / BOWEL***
❑	❑	Change in Bowel Habits: ___Constipation; ___Diarrhea
❑	❑	Change in Stool Appearance: ____ Black stools ____ Red blood in stools
❑	❑	Stomach pain
❑	❑	Nausea / Vomiting

REVIEW OF SYSTEMS

Absent	Present	SKIN / LYMPHATIC
❑	❑	Skin breakdown
❑	❑	Changes in mole
❑	❑	Rash
❑	❑	Lumps: ___neck; ___arm pit; ___groin
❑	❑	Hair pattern changes
Absent	***Present***	***ORTHOPEDIC / MUSCULOSKELETAL***
❑	❑	Joint pain / swelling / instability / loss of motion (list joints):
❑	❑	Foot problems
Absent	***Present***	***NEUROLOGIC***
❑	❑	Headache
❑	❑	Memory problems
❑	❑	Decreased smell / taste
❑	❑	Vision problems: ___double vision; ___blurred vision; ___loss of vision
❑	❑	Hearing problems: ___hearing loss; ___ringing
❑	❑	Swallowing problems / choking
❑	❑	Arm / Leg weakness
❑	❑	Arm / Leg numbness, tingling, pain
❑	❑	Pain: ___back; ___neck; ___arm; ___leg
❑	❑	Fainting / Light headedness / Vertigo
❑	❑	Impaired Balance
❑	❑	Loss of bladder control
❑	❑	Loss of bowel control
❑	❑	Loss of sensation in genital / rectal area
Absent	***Present***	***WOMEN'S HEALTH***
❑	❑	Abnormal Vaginal Bleeding
❑	❑	Currently Painful Menstrual Periods
❑	❑	Increased Back Pain with Menstrual Periods
❑	❑	Pap Smear Within the Last Two (2) Years
❑	❑	Perform Monthly Breast Self-Exam
❑	❑	Other Menstrual Problems, Explain:
		OTHER

Patient's Signature: ______________________________________ Date: ___________________

MD/DO Reviewed: _______________________________________ Date: ___________________