Monmouth Rehab Professionals
Patient Medical History

Name____________________________ Date______________
Date of Accident__________________

<u>Please Circle Appropriate Response</u>

1. History of a heart problem………………………..Yes/No
2. Pace Maker……………………………………..Yes/No
3. High Blood Pressure………………………………Yes/No
4. Cancer…………………………………………..Yes/No
5. Tumors or Cysts Removed………………………..Yes/No
6. Tuberculosis………………………………………Yes/No
7. Skin Disorders……………………………………..Yes/No
8. HIV Positive………………………………………Yes/No
9. Lung Disease………………………………………Yes/No
10. Asthma…………………………………………..Yes/No
11. Are you pregnant…………………………………...Yes/No
12. Headaches………………………………………..Yes/No
13. Dizziness…………………………………………Yes/No
14. Blurred Vision……………………………………Yes/No
15. Vomiting or Nausea………………………………Yes/No
16. Numbness…………………………………………Yes/No
17. Arthritis……………………………………………Yes/No
18. Osteoporosis………………………………………Yes/No
19. Internal Implants (Metal or Plastic)…………………..Yes/No
20. Diabetes……………………………………………Yes/No
21. Hepatitis……………………………………………Yes/No
22. Circulation Problems………………………………..Yes/No
23. Sensitivity to Heat or Ice Packs………………………Yes/No
24. Other…..Yes/No

Signature of Patient__________________________________