LAKEVIEW REGIONAL
REHABILITATION AND SPORTS MEDICINE

NEW PATIENT HISTORY FORM

Name: _____ Referred by: _____
Birthdate (mm/dd/yyyy): ___ / ____ /_____ Primary Care Physician: _____
_____ _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

PAST MEDICAL HISTORY: Please check all that apply, even if your medications have fixed the problem (examples: high blood pressure, high cholesterol, asthma, heart attack, depression, etc).

❑	High or low blood pressure	❑	Headaches
❑	Heart problems	❑	Stroke or head injury
❑	Pacemaker	❑	Depression
❑	Angina	❑	Muscular Disease
❑	Shortness of breath	❑	Seizures, fainting or dizziness
❑	Asthma/sinus problems	❑	Fractures
❑	Lung problems	❑	Bursitis/tendonitis
❑	Recent gain or loss of weight	❑	Arthritis
❑	Liver disease	❑	Neck/back pain
❑	Kidney/bladder problems	❑	Glasses or contacts
❑	Bowel problems	❑	Hearing loss
❑	Thyroid problems	❑	Infections disease
❑	Diabetes	❑	Skin conditions
❑	Cancer	❑	Smoking history
❑	Osteoporosis	❑	Other

Have you fallen in the last 6 months?	YES	NO
Have you had a weight loss of 10 lbs or more in the past 30 days?	YES	NO
Do you bruise easily?	YES	NO
Have you suffered abuse?	YES	NO
Do you feel safe at home?	YES	NO

PAST SURGICAL HISTORY: Please ***list prior surgeries with approximate dates***, no matter how long ago (examples: appendectomy, gall bladder removal, tonsillectomy, hip or knee surgery, etc).

OPERATION	*YEAR*	*REASON*
1.		
2.		
3.		
4.		
5.		

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Do you have ALLERGIES to medication, food, latex, adhesives? ❑ **Yes** ❑ **No**
If yes, please explain:

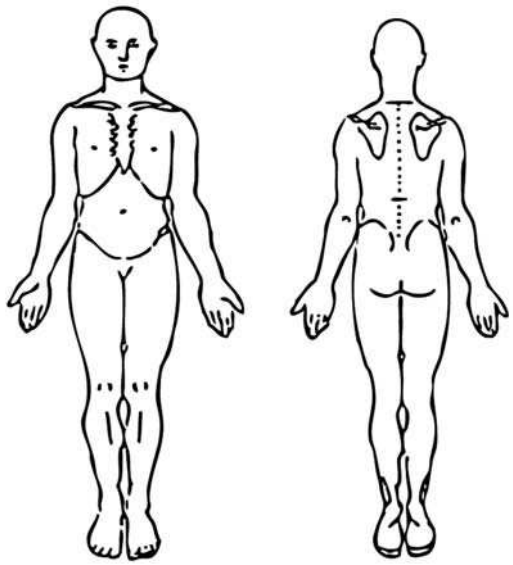
Please list **CURRENT MEDICATIONS** with dosage (including asprin, advil, multivitamins)

1. 5.
2. 6.
3. 7.
4. 8.

Mark the location(s) of your pain with an "x" on the diagram. If whole areas are painful, shade in the painful area.

Indicate your pain type by circling a letter or letters

A Deep (inside)
B Superficial (on the skin)
C Constant (all the time)
D Intermittent (starts & stops)
E Aching
F Burning
G Shooting
H Other



Please rate your pain by circling on the scale below, with "0" being no pain, and "10" being excruciating pain

0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain?
What makes it better?
What makes it worse?

Current Symptoms:

YES	NO	Numbness or tingling	YES	NO	Sleeplessness
YES	NO	Weakness/fatigue	YES	NO	Loss of balance/falling
YES	NO	Extremity swelling	YES	NO	Memory loss
YES	NO	Cold extremities	YES	NO	Difficulty swallowing
YES	NO	Hoarseness	YES	NO	Chronic coughing
YES	NO	Coordination problems	YES	NO	Concentration problems
YES	NO	Night sweats/chills/fever	YES	NO	Blurred or double vision

I learn better by:	❑ Hearing	❑ Reading	❑ Pictures	❑ All

Patient Signature: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

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