REHAB ASSOCIATES

HEALTH HISTORY

Patient Name ______________________ Date of Report ____________

Diagnosis ______________________ Physician ____________

MEDICAL HISTORY:

		NO	YES
1.	Have you had a heart attack?	☐	☐
2.	Have you had heart surgery?	☐	☐
3.	Do you have heart disease?	☐	☐
4.	Have you been told by an M.D. you have angina/palpitations?	☐	☐
5.	Have you had a stroke?	☐	☐
6.	Is your blood pressure over 180/104?	☐	☐
7.	Are you pregnant?	☐	☐

ANY "YES" RESPONSES REQUIRE CONSULTATION WITH, AND FURTHER CLEARANCE BY, THE PRESCRIBING PHYSICIAN BEFORE TESTING MAY CONTINUE!

Clearance Granted? ☐NO ☐YES By: ____________

Date obtained clearance: ____________

(Check only positive responses)

(a) ☐ Asthma
(b) ☐ Hernia
(c) ☐ Allergies
(d) ☐ Epilepsy/Seizure
(e) ☐ FX/Dislocations
(f) ☐ Surgery
(g) ☐ Prosthesis/Brace
(h) ☐ Drug/Alcohol abuse
(i) ☐ Diabetes
(j) ☐ Incontinence
(k) ☐ Cancer

Explanation of all positive responses and other conditions not listed:

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Present medications: ____________

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Initial B/P Time: ____________ B/P ____________ Pulse ____________

Ending B/P Time: ____________ B/P ____________ Pulse ____________