PARAMOUNT
Rehabilitation Services

PAST MEDICAL HISTORY
Have you ever been told you have any of the following?

Cancer	Yes	No	**Dialysis**	Yes	No
Heart Bypass	Yes	No	**COPD**	Yes	No
Congestive Heart Failure	Yes	No	**Recent Weight Loss**	Yes	No
Cardiac Stents	Yes	No	**Hernia**	Yes	No
High Blood Pressure	Yes	No	**Allergy to Heat / Ice**	Yes	No
Low Blood Pressure	Yes	No	**Hepatitis**	Yes	No
Asthma	Yes	No	**Bowel / Bladder Problem**	Yes	No
Diabetes	Yes	No	**Shingles**	Yes	No
Osteoporosis	Yes	No	**Fibromyalgia**	Yes	No
Thyroid problems	Yes	No	**Kidney Disease**	Yes	No
Arthritis	Yes	No	**Stroke**	Yes	No
Pacemaker / Defibrillator	Yes	No	**Seizures / Epilepsy**	Yes	No
Blood Clot	Yes	No	**Other** _____		
Depression / Anxiety	Yes	No	**Latex Allergy**	Yes	No

Currently, are you experiencing any of the following? (circle all that apply):

- ☐ Fever/chills/sweats
- ☐ Poor balance (falls)
- ☐ Unexplained weight loss
- ☐ Pregnancy
- ☐ Numbness/tingling
- ☐ Incontinence
- ☐ Difficulty swallowing
- ☐ Circulation Problems
- ☐ Shortness of breath
- ☐ Blood Clot
- ☐ Dizziness
- ☐ Nausea/vomiting
- ☐ Headaches

Have you ever been told you have any of the following? (IF YES YOU WILL NEED TO FILL OUT ADDITIONAL INFORMATION- PLEASE SEE RECEPTIONIST FOR SECONDARY FORM

H1N1	Yes	No	**VRE**	Yes	No
MRSA	Yes	No	**Current Open Wound**	Yes	No
Scabies	Yes	No	**Pink Eye**	Yes	No
TB	Yes	No	**Lice**	Yes	No
Current Cough or Cold	Yes	No	**Current Shingles**	Yes	No

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History of fractured bones (If yes, please list where below with approximate dates)? ◯ Yes ◯ No

Any metal implants, loop recorder, baclofen pump, insulin pump (If yes please list which and location below)? ◯ Yes ◯ No

Please list any lifting, weight-bearing, or other restrictions/precautions related to your condition that have been given you by your physician:

Please list your surgical history with approximate dates:

Please list your current medications:

Please check any of the following that you have recently had:

☐ X-Ray ☐ CAT Scan ☐ PET Scan ☐ EMG ☐ MRI ☐ Other Diagnostic Testing

Please list results from any above circled testing (if known):

Is there anything else you think we should know about your general health or current condition?

How did you hear about Paramount please check all that apply:

☐ My Doctor Recommended Paramount ☐ Website ☐ Facebook ☐ Drove By

☐ Family or Friend Recommended Paramount ☐ Past Patient ☐ Other: _____

Please check below if you would like to receive the following types of reminders for each scheduled appointment:

☐ Phone Call Reminders ☐ Text Reminders ☐ Email Reminders

SUBMIT