CENTRO DE REHABILITACION Y ELECTRODIAGNOSITICO DE HATO REY

INTAKE FORM

Name: _____ Last name: _____

HEIGHT: _____ WEIGHT: _____

***ONLY FOR MEDICAL USE ***

VITALS: BLOOD PRESSURE: _____/_____PULSE: _____

ALLERGIES/INTOLERANCE: ☐ **NOT ALLERIGIC TO MEDICATIONS**

☐ SULFA ☐ LIDOCAINE ☐ ASPIRIN ☐ PENICILLIN

☐ IODINE ☐ SHELLFISH ☐ OTHER: _____

CURRENT MEDICATIONS: ☐ **I DO NOT USE ANY MEDICATIONS**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I AUTHORIZE THE PHYSICIAN ELECTRONIC ACCESS TO ALL MY MEDICATION HISTORY AT PARTICIPATING PHARMACIES.

☐ YES ☐ NO

SOCIAL HISTORY:

SMOKER O FORMER SMOKER?	☐ YES	☐ NO	FREQUENCY:	☐ DAILY	☐ SOME DAYS	☐ **FORMER SMOKER**
DO YOU DRINK ALCOHOL?	☐ YES	☐ NO	FREQUENCY:	☐ DAILY	☐ 1 or 2 X WEEK	☐ OCCASIONALLY
HAVE YOU USED ILLEGAL DRUGS?	☐ YES	☐ NO	CURRENTLY?:	☐ YES	☐ NO	
DO YOU EXERCISE?	☐ YES	☐ NO	FREQUENCY:	☐ 5 OR MORE DAYS	☐ 1-3 DAYS	☐ OCCASIONALLY
What type of exercise or sport do you do?						
IN WHAT POSITION DO YOU SLEEP?	☐ **PRONE**	☐ **SUPINE**	☐ **SIDEWAYS**			

FAMILY HISTORY:

CHECK IF YOUR MOTHER OR FATHER HAS HISTORY OF THE FOLLOWING CONDITIONS:

CONDITION	MOTHER	FATHER	CONDITION	MOTHER	FATHER
ARTHRITIS			HYPERTHYROIDISM		
CANCER			HYPOTHYROIDISM		
CEREBROVASCULAR ACCIDENTS			OSTEOPOROSIS		
DIABETES			PSIQUIATRIC CONDITION		
CARDIAC DISEASE			OTHER: _____		
HYPERTENTION					

CHECK THE FOLLOWING CONDITIONS AND CHECK THE ONES THAT APPLY TO YOU:

PAST MEDICAL HYSTORY	APPLY	PAST SURGERIES	YEAR	APPLY
ANEMIA		ACL REPAIR		
ANGINA		BACK SURGERY		
ASTHMA		CARPAL TUNNEL SURGERY		
ATRIAL FIBRILLATION		CERVICAL SPINE SURGERY		
CANCER		HEART SURGERY		
DIABETES		HIP REPLACEMENT		
DEEP VEIN THROMBOSIS		KNEE ARTHROSCOPY		
HEPATITIS		KNEE REPLACEMENT		
HIGH CHOLESTEROL		MASTECTOMY		
HYPERTENTION		ROTATOR CUFF TEAR REPAIR		
HYPERTHYROIDISM		SHOULDER REPLACEMENT		
HYPOTHYROIDISM		WRIST SURGERY		
INFECTIOUS DISEASE		OTHER: _____		
CHRONIC RENAL FAILURE		_____		
OTHER:_____				

Continue on next page

CHECK *ONLY* THE SYMPTOMS THAT *CURRENTLY* APPLY TO YOU

CONSTITUTIONAL	APPLY	MUSCULOSKELETAL	APPLY
FEVER		MUSCLE CRAMPS	
CHILLS		LOSS OF MUSCLE MASS	
WEIGHT GAIN		MUSCLE WEAKNESS	
WEIGHT LOSS		MUSCULAR PAIN OR SENSIBILITY	
CHANGE IN APPETITE		CERVICAL PAIN	
HEAD/NECK	**APPLY**	BACK PAIN	
VISUAL CHANGES		SHOULDER PAIN	
EARACHE		JOINT PAIN	
DEAFNESS/LOSS OF HEARING		JOINT STIFFNESS	
LOSS OF SMELL		JOINT SWELLING	
SOAR THROAT		FRACTURES	
DIFFICULTY SWALLOWING		POSTURE ANOMALIES	
CHANGE IN TASTE		**NEUROLOGIC**	**APPLY**
MASS AT NECK		SEIZURES	
ENDOCRINOLOGY	**APPLY**	TROUBLE CONCENTRATING	
EXCESSIVE THIRST		DIFICULTY WALKING	
INTOLERANCE TO COLD OR HEAT		HEADACHES	
EXCESIVE URINATION		FAINTING	
THYROID NODULE		MEMORY LOSS	
CARDIOLOGY	**APPLY**	INVOLUNTARY MOVEMENTS	
CHEST PAIN		POOR COORDINATION	
POOR CIRCULATION		NUBMNESS	
BLOOD CLOTS		SPASTICITY	
IRREGULAR HEART RYTHM		**PSIQUIATRIC**	**APPLY**
PALPITATIONS		ANXIETY	
PAIN AT LEGS WHILE WALKING		DEPRESSION	
LEG EDEMA		CHANGE IN MOOD	
VARICOSE VEINS		NERVOUSNESS	
GASTROINTESTINAL	**APPLY**	TROUBLE SLEEPING	
ABDOMINAL PAIN		**RESPIRATORY**	
GASTROESOPHAGEAL REFLUX		DIFICULTY BREATHING	
NAUSEA/VOMITING		ASTHMA	
BLOOD VOMIT		COUGHING BLOOD	
HEMORROIDS		SLEEP APNEA	
FREQUENT CONSTIPATION		STRIDOR	
FREQUENT DIARRHEA		RESPIRATORY INFECTION	
STOMACH ULCER		**SKIN**	**APPLY**
BLOOD IN STOOL		ITCHINESS	
GENITOURINARY	**APPLY**	RASH	
URINARY INCONTINENCE		ECHYMOSIS (BLACK & BLUE)	
BLOOD IN URINE		SKIN ULCER	
KIDNEY STONES			
DIFFICULTY URINATING			

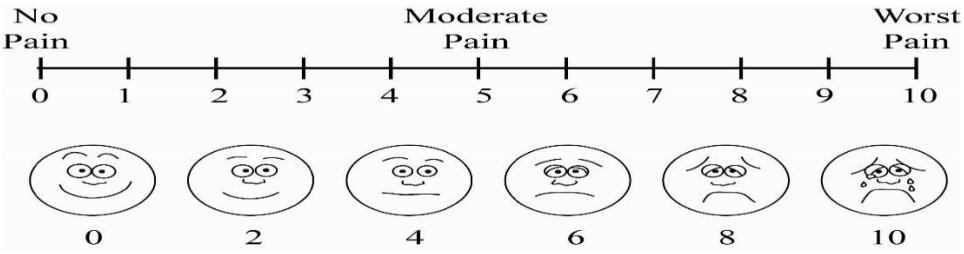
REASON FOR TODAY'S VISIT: _____

DATE THAT PAIN STARTED:_____

DO YOU HAVE PAIN? : ☐ YES ☐ NO

LOCATION OF YOUR PAIN: _____

SEVERITY OF PAIN:
(Circle the Number)



PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZED REPRESENTATIVE

SIGNATURE: _____

NAME: _____ RELATIONSHIP: _____

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