Physical Medicine and Rehabilitation of LONG ISLAND

PATIENT INFORMATION SHEET

NAME: _____ **GENDER:** _____ **DOB:** _____

Reason for the visit today: _____

Name of referring physician: _____

MEDICATIONS: (List all medications you take, including over the counter and vitamins. Include specific doses and when taken)

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES: List any drug allergies.

_____ _____ _____

PERSONAL MEDICAL HISTORY: (Circle all that apply)

ADHD	Headaches	Hiatal Hernia	Osteopenia/Osteoporosis
Alcoholism	Crohn's Disease	High Blood Pressure	Parkinson's Disease
Allergies – Seasonal or Latex	COPD/Emphysema	Kidney Stones	Peripheral Vascular Disease
Anemia	Dementia	Kidney Disease	Peptic Ulcer
Anxiety	Depression	High Cholesterol	Psoriasis
Arrhythmia (irregular heartbeat)	Diabetes: 1 or 2	HIV	Pulmonary Embolism (PE)
Arthritis	Diverticulitis	Hepatitis	Rheumatoid Arthritis
Asthma	DVT (Blood Clot)	Irritable Bowel Syndrome	Seizure Disorder
Bipolar	GERD (Acid Reflux)	Lupus	Sleep Apnea
Bladder Problems / Incontinence	Glaucoma	Liver Disease	Stroke
Bleeding Problems	Heart Disease	Macular Degeneration	Thyroid Disorder
Cancer: _____	Heart Attach (MI)	Neuropathy	Ulcerative Colitis

Other medical problems not listed above:

_____

_____

SURGICAL HISTORY: List all prior surgeries and approximate dates performed.

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