**CENTRAL FLORIDA INJURY**
**Rehabilitation**

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# PATIENT HISTORY QUESTIONNAIRE

Name _____ Date _____
History reviewed by _____M.D. Date _____

## REVIEW OF SYSTEMS:

If you are **currently** having any problems in the following areas, please check.

| | | | |
|---|---|---|---|
| ○ Fevers/Nightsweats | ○ Frequent headaches | ○ Nausea/Vomiting | ○ Rashes |
| ○ Shaking Chills | ○ Cough | ○ Stomach pain | ○ Anxiety |
| ○ Recent weight loss | ○ Shortness of breath | ○ Blood in stool | ○ Depression |
| ○ Bleeding gums | ○ Coughing up blood | ○ Loose stools | ○ Calf cramps |
| ○ Frequent nosebleeds | ○ Hoarseness | ○ Loss of appetite | ○ Joint pain/swelling |
| ○ Visual problems | ○ Chest pain | ○ Difficulty urinating | ○ Neck pain/stiffness |
| ○ Hearing problems | ○ Abnormal heartbeat | ○ Burning on urination | ○ Back pain/stiffness |
| ○ Dizziness/Fainting | ○ Ankle swelling | ○ Blood in urine | ○ Arm or leg weakness |
| ○ Loss of consciousness | ○ Leg pain | ○ Incontinence | ○ Numbness/tingling |

**Please use box below for other conditions not listed or additional comments**

Patient's Signature _____ Date _____

**Established patients ONLY – If it has been more than 6 weeks since you have seen the doctor have there been ANY changes in your health or the above?**

○ **No, there has NOT been any change in my health.**

○ **YES, there has been a change in my health. Please explain below:**

_____
_____
_____
_____

Patient's Signature_____Date_____