**Access Rehab Centers**
A Waterbury Hospital & Easterseals Partnership in Physical Rehabilitation

# MEDICAL HISTORY/ EMERGENCY INFORMATION
## CONFIDENTIAL

Patient's Name: ___________________________________ DOB: _______________ Patient Act. # __________________

Primary Care Physician __________________________________________________________ Phone: ________________

In an emergency, who should we contact to make medical decisions? __________________________________ Phone: __________________

**MEDICATION PROFILE** (Include prescriptions, non-prescriptions, herbal supplements, vitamins, inhalers, eye drops, etc.)

❑ Not taking any medications

| MEDICATION | DOSAGE | FREQUENCY | PHYSICIAN PRESCRIBING | PHONE NUMBER |
|---|---|---|---|---|
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**Allergies/Reactions**: ❑ No Known Drug Allergies ❑ See addendum for additional **Medication** Profile.

______________________________________________________________________________________________

**Please check Yes or No for each:**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | | Heart Attack | | | Pacemaker | | |
| Diabetes | | | Seizures | | | Epilepsy | | |
| Stroke | | | Arthritis | | | Cancer | | |
| Asthma | | | Broken Bones | | | Dizziness | | |
| Headaches | | | Osteoporosis | | | Lung Disease | | |
| Tuberculosis | | | HIV+/AIDS | | | Hepatitis | | |
| Joint Replacement | | | Metal Implants | | | Bladder Trouble | | |
| Psychiatric Care | | | *For Woman Only*: Could you be pregnant now? ❑ Yes ❑ No | | | | | |
| Other: | | | | | | | | |

**Please list hospitalizations/surgeries/pertinent procedures.**

❑ No Hospitalizations/Surgeries/Procedures

| | **When did this happen?** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

❑ See addendum for additional Hospitalizations/Surgeries/Procedures.

Is this related to Worker's Comp? ❑ Yes ❑ No

Is this related to a MVA? ❑ Yes ❑ No

Are you receiving Home Care now? ❑ Yes ❑ No Date of Discharge if applicable: _______________________

Please share any additional information that would be helpful to our staff: ______________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

_____________________________________________ _____________________________________________

Signature of Person Completing Form Date Reviewed by Date

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# MEDICAL HISTORY – ADDENDUM

Patient's Name: ______________________________ DOB: _____________ Patient Act. # ________________

**MEDICATION PROFILE** (CONTINUED FROM PAGE 1)

| MEDICATION | DOSAGE | FREQUENCY | PHYSICIAN PRESCRIBING | PHONE NUMBER |
|---|---|---|---|---|
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| **Hospitalizations/Surgeries/Pertinent Procedures** (CONTINUED FROM PAGE 1) | **When did this happen?** |
|---|---|
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |
| 11. | |
| 12. | |
| 13. | |
| 14. | |
| 15. | |

_______________________________________________ _____________________________________________

Signature of Person Completing Form Date Reviewed by Date