Center for Transitional Neuro-Rehabilitation
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CTN Medical History Form

Patient Name: _____ **Date of Birth**: _____ **Age**: _____
□ Right Handed □ Left Handed

Form Completed by:
□ Self □ Relative □ Spouse □ Significant Other □ Friend □ Other _____

Reason for visit:

□ TBI □ Stroke □ Other Neurological Condition _____

Sensory Deficits:
□ None □ Vision □ Hearing □ Speech □ Sensation □ Other _____
Assistive Device Used for Communication: _____

Drug Allergies: _____
_____

_____

Medications:
Dose strength and frequency (prescribed and over-the-counter)

Name of Medication	Dosage (mg) # of pills	Frequency (include AM/PM)

Pharmacy Information:

Name of local pharmacy: _____ Phone: _____

Name of mail order pharmacy: _____ Phone: _____

Past Medical History and Dates Diagnosed:

□ Diabetes _____
□ High Blood Pressure _____
□ Heart Attack _____
□ Stroke _____
□ TBI _____
□ Seizures _____
□ Liver Disease _____
□ Asthma _____
□ Lung Disease _____
□ Kidney Disease _____
□ Cancer/Tumors _____
□ HIV/AIDS _____
□ Surgery _____
□ Trauma _____
□ Thyroid problems _____
□ Ulcers _____
□ Back problems _____
□ Heart Valve problems _____
□ Hyperlipidemia _____
□ Other Medical Illnesses _____

Past Surgical History and Dates of surgeries:

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Artificial Parts:

□ Implants □ DBS/VNS □ Heart Valve □ Limb prosthesis

□ Pacemaker/AICD □ Other: _____

Family History:

□ Diabetes	□ Mother	□ Father	□ Sibling
□ High blood pressure	□ Mother	□ Father	□ Sibling
□ Heart Attack	□ Mother	□ Father	□ Sibling
□ Stroke	□ Mother	□ Father	□ Sibling
□ Seizures	□ Mother	□ Father	□ Sibling
□ Multiple Sclerosis	□ Mother	□ Father	□ Sibling
□ Parkinson Disease	□ Mother	□ Father	□ Sibling
□ Cancer	□ Mother	□ Father	□ Sibling

□ Other: _____

Father died age _____ of _____

Mother died age ____ of _____

Brother died age ____ of _____

Sister died age _____ of _____

_____ died age _____ of _____

_____ died age _____ of _____

Social/Lifestyle History:

Marital Status: □ Married □ Single □Divorced □ Widowed □ Other

Spouse Age: _____ Health Status: _____

Children: □ Male □ Female Age: _____ Health Status: _____

□ Male □ Female Age: _____ Health Status: _____

□ Male □ Female Age: _____ Health Status: _____

Lost pregnancies/miscarriages: _____ Last menstrual period: _____

Occupation: _____ Education: _____

Physical Exercise: _____ Activities/Hobbies: _____

Tobacco: 0 _____<1ppd _____1ppd _____>1ppd _____ Quit: _____ Years: _____

Alcohol: 0 _____ 1-5 per week _____>5 per week ____ Quit: _____ Years: _____

Recreational Drug Use: _____ IV Drug Use: _____

HIV high risk behavior: _____ STD: _____

On average, how many hours of sleep do you get? Weekdays _____ Weekends _____

Which meals do you eat regularly? Check all the apply:

□ Breakfast □ Lunch □ Dinner □ Snacks □ Times: _____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work_____ Family_____ Social_____ Financial_____ Health_____ Other_____

Name/specialty/contact information for your other doctors:

Name	Specialty	Phone Number	Fax Number

Other

Night Sweats	YES / NO	Change in daily living	YES / NO
Chronic Cough	YES / NO	Change in walking ability?	YES / NO
Coughing up blood	YES / NO	Fallen in the last 90 days?	YES / NO
Nausea or Vomiting more than 7 days	YES / NO	Any learning needs or disability?	YES / NO
Unplanned Weight loss	YES / NO	Last education level completed_____	
Difficulty chewing / swallowing	YES / NO	Language preferred _____	

Location of pain: _____

Description of pain: _____

Emotional Health

What emotional difficulties are you having at this time?

_____

_____

What are your goals/expectations for treatment?

_____

_____

Have you ever been prescribed psychiatric medications by an Outpatient provider? ☐ Yes ☐ No

If yes when and by whom?

_____

_____

Please list past psychiatric medications if yes to question above.

_____

_____

Please list any prior psychiatric hospitalizations, including substance rehab programs below:
If none, check here ☐

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you or any blood relatives ever been diagnosed with any of the following?

✓	Condition	Self	Relative	Relationship to you
	Schizophrenia			
	Bipolar Disorder			
	Anxiety Disorder			
	☐ OCD			
	☐ Panic Attacks			
	☐ Social Anxiety Disorder			
	☐ Post-Traumatic Stress/PTSD			
	☐ Generalized Anxiety			
	Depression			
	Alcoholism			
	Eating Disorder			
	Psychiatry hospitalizations – "Nervous Breakdowns"			
	ADHD			
	Other			

Name: _____DOB: _____Date: _____

PCP: _____ Referring Provider: _____

General

Fevers	Yes
Chills	Yes
Sweats	Yes
Loss of Appetite	Yes
Fatigue	Yes
Weight Gain or Loss	Yes
Insomnia	Yes
Are you a safe driver?	Yes
Auto accidents in the past year?	Yes

Cardiovascular

Chest pain	Yes
Fainting spells	Yes
Ankle swelling	Yes
Palpitations	Yes
Shortness of breath	Yes

Skin

Unexplained rashes	Yes
Alopecia	Yes
Suspicious lesions	Yes
Unexplained itching	Yes
Visited Dermatologist in past year	Yes

Musculoskeletal

Joint pain	Yes
Muscle cramps	Yes
Muscle weakness	Yes
Joint swelling	Yes
Joint stiffness	Yes
Back pain	Yes
Arthritis	Yes

Endocrine

Cold intolerance	Yes
Increased thirst	Yes
Large quantity of urine	Yes
Heat intolerance	Yes
Increased appetite	Yes

OFFICIAL USE ONLY
Height: _____ Weight: _____
B/P: _____ /_____ Pulse: _____
Handedness: R / L

Ear, Nose and Throat

Ear aches	Yes
Loss of Hearing	Yes
Difficulty swallowing	Yes
Ringing in your ears	Yes
Decreased hearing	Yes
Nasal congestion	Yes

Respiratory

Coughing	Yes
Wheezing	Yes
Night sweats	Yes
Coughing up blood	Yes
Nausea/vomiting more than 7 days	Yes
Unplanned weight loss	Yes
Difficulty chewing/swallowing	Yes
Change in walking ability	Yes

Gastrointestinal

Nausea	Yes
Constipation	Yes
Blood or black stools	Yes
Vomiting	Yes
Changes in bowel habits	Yes
Diarrhea	Yes
Abdominal pain	Yes

Neurologic

Transient limb paralysis	Yes
Tingling sensation	Yes
Headache	Yes
Weakness	Yes
Seizure	Yes
Unsteadiness	Yes
Tremor	Yes
Speech difficulties	Yes
Numbness	

Heme/Lymphatic

Abnormal bruising	Yes
Abnormal bleeding	Yes
Enlarged lymph nodes	Yes

Eyes

Blurred vision	Yes
Double vision	Yes
Loss of partial visual field	Yes
Vision Loss	Yes
Eye pain	Yes
Light sensitivity	Yes
Wear eye glasses	Yes
Eye infections	Yes
Eye injuries	Yes
Glaucoma	Yes
Loss of Side vision	Yes
Vision worse in bright light	Yes
Droopy eyelids	Yes
Flashes of light	Yes
Burning in eyes	Yes
Lazy eye	Yes
Visual hallucinations	Yes
Visual blurring or loss at near	Yes
Visual blurring or loss at distance	Yes

Genitourinary

Pain upon urination	Yes
Blood in urine	Yes
Frequent urination	Yes
Frequent urination at night	Yes
Difficulty starting to urinate	Yes
Loss of bladder control	Yes
Loss of pregnancy/miscarriage	Yes

Psychiatric

Depression	Yes
Hallucination	Yes
Irritability	Yes
Anxiety	Yes
Paranoia	Yes
Panic attacks	Yes
Memory loss	Yes

Allergy/Immunology

Persistent infections	Yes
HIV exposure	Yes