Follow-up appointment with referring physician (date/time):  Current medications (names only):   List provided					
	If Y	eceived outpatient and/or home heares 'ES, where:  Hospitalizations related to this con		· 	# visits:
X-rays	s/MR	/Diagnostic tests <u>related to this co</u>	ndition (lo	ocation and date):	
Have YES	you NC	ever had any of the following - Pl		appropriate box and comr	ment as needed:
		Medication allergies	,		
		Latex sensitivity/allergy			
		Adhesive sensitivity/allergy			
		Food sensitivity/allergy			
		Pool Chemical sensitivity/allergy			
		Arthritis/neuritis			
		Diabetes			
		Broken bones			
		Concussion/head injury			
		Dizziness			
		Shortness of breath			
		Stroke			
		Swallowing difficulties			
		Frequent/severe headaches			
		Cardiac/Heart Issues			
		Cancer			
		High blood pressure			
		Seizures			
		Pacemaker/Defibrillator			_
		Medication Pump/Spinal Stimulato			
		Other Surgeries			
WOM	IEN C	ONLY: Are you now or could you be	pregnant	? □Yes □No	
			-		
Comp	leted	By:		Relationship to Patient:	Date:
IF UP	DATI	NG INFORMATION CONTAINED	ON THIS F	ORM: (Apply initials and d	ate next to each change).
Updat	ted by	/: l	Relationsh	ip to Patient:	Date:
Patie	ent:				
				Hand	over Hospital
Unit #:					<b>over Hospital</b> Rehab Centers
DOB				"""	
MD#C	755 0	5/04 10/05 02/06 02/06 06/00 04/11		İ	

NEW PATIENT MEDICAL HISTORY