DATE: _____

FILE#: _____

DR. MICHAEL ADBELSAYED

Physical Medicine & Rehabilitation

NEW PATIENT FORM

PERSONAL INFORMATION

First Name:_____

Last Name:_____

Address: _____

City: _____ State:_____ Zip Code: _____

SS# _____ - _____ - _____

DOB: _____

PHONE: _____

EMAIL: _____

EMERGENCY CONTACT

Name:_____ Relationship: _____

Phone: _____

REFERRING DOCTOR: _____

NEW PATIENT HISTORY

Briefly explain the reason for your doctor visit today?

_____

_____

Check Any That Apply to Your Medical History

☐ High Blood Pressure
☐ Diabetes
☐ Rheumatoid Arthritis
☐ Spinal Cord Injury
☐ Parkinson's Disease
☐ High Cholesterol
☐ Stroke
☐ Ulcers
☐ Spinal Stenosis
☐ Cancer If Yes, Type: _____
☐ Heart Attack
☐ Osteoarthritis
☐ Lupus
☐ Multiple Sclerosis

Do you have any broken bones?

Where?_____ When? _____

Do you have any injuries associated with a car accident? ☐ No ☐ Yes

If YES, Explain: _____

Do you have any injuries associated with a sport's activity ? ☐ No ☐ Yes

If YES, Explain: _____

List All Surgeries you have had:

When _____ Type: _____ Outcome: _____

When _____ Type: _____ Outcome: _____

When _____ Type: _____ Outcome: _____

Family

MOTHER: ☐ Living ☐ Deceased at age_____ Cause of Death: _____

FATHER:: ☐ Living ☐ Deceased at age_____ Cause of Death: _____

SOC History: How much tobacco do you use? ☐ Do Not Smoke ☐ Yes

If YES, Explain: _____

SOC History: How much alcohol do you use? ☐ Do Not Drink Alcohol ☐ Occasionally ☐ Frequently

Do you Use or Have Used Drugs in the past? ☐ No ☐ Yes

Are you married? ☐ No ☐ Yes **Children?** ☐ No ☐ Yes _____ How Many?

Do You Live in a:

☐ House # Floors? _____ #Steps to Enter Home? _____

☐ Apartment Which Floor? _____

Do you own any of the following? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bedside Commode

☐ Shower Chair or Tub Bench ☐ Hospital Bed

Do you require any assistance walking? ☐ No ☐ Yes

Do you require any assistance with any of your daily activities? ☐ No ☐ Yes

If Yes, Explain: _____

List All Medications you currently are taking including (OTC) Over the Counter and Supplements:

_____

_____

List All Allergies to any Foods or Medicine: ☐ None ☐ Yes, See Below

_____

_____

REVIEW OF SYSTEMS: (CIRCLE ANY OF THE FOLLOWING YOU ARE EXPERIENCING)

CHRONIC HEADACHES	VISUAL CHANGES	HEARING LOSS	RINGING IN THE EARS
DIFFICULTY SWALLOWING	CHEST PAIN WITH ACTIVITY OR AT REST		SHORTNESS OF BREATH
COUGH (PRODUCTIVE)	ABDOMINAL PAIN,	INCONTINENCE OF BOWEL/BLADDER	
BLOOD IN URINE OR STOOL	KIDNEY STONE	GALL STONES	CONSTIPATION
DIARRHEA	WEIGHT GAIN/LOSS	LOSS OF APPETITE	INSOMNIA
DEPRESSION	ANXIETY	FATIGUE	STRENGTH LOSS,
NUMBNESS	TINGLING	PAIN	MUSCLE SPASMS.

When did your loss of strength start and what preceded this?

_____

_____

If you experience PAIN, where is your PAIN and what is the Distribution of PAIN?

_____

_____

When did your Pain start and what preceded this?

_____

Are you satisfied with your current level of fitness: ☐ Yes ☐ No

Would you like to Discuss this: ☐ Yes ☐ No

Do you exercise regularly: ☐ Yes ☐ No

If YES, What Type and How Often: _____

Are you trying to lose weight: ☐ Yes ☐ No **Would you like to Discuss this:** ☐ Yes ☐ No

Do you have any additional questions NOT addressed in this form? If so, list below

_____

_____

_____

_____

_____