FLOYD
REHABILITATION
ADULT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Referring Physician: _____ Diagnosis: _____

Current Occupation: _____

Do you have any religious or cultural concerns that will affect your care/treatment? ☐ YES ☐ NO

If yes, please explain _____

Are you currently pregnant? ☐ YES ☐ NO

Please circle any of the following that currently apply:

Anemia	Dizziness/Fainting	Kidney Problems	Stroke
Anxiety	Gastrointestinal	Meningitis	Suicidal Thoughts
Arthritis	Headaches	Polio	Thyroid Problems
Cancer	Head Injury	Psychological Disorder	Tuberculosis
Depression	Heart Condition	Rheumatic Fever	Vascular Disease
Diabetes	High Blood Pressure	Seizures	

Do you have a blood disorder? ☐ **YES** ☐ **NO**

Do you take blood thinners? ☐ **YES** ☐ **NO**

Any Known Allergies: _____

Do you currently have or have you ever had MRSA? ☐ **No** ☐ **Yes, Dates:** _____

Please list any past surgeries and/or injuries

Approximate Dates	Injury

Do you have pain now? If so, where is most of your pain?

_____

_____

Is there anything that increases or decreases this pain?

_____

_____

Patient Identification

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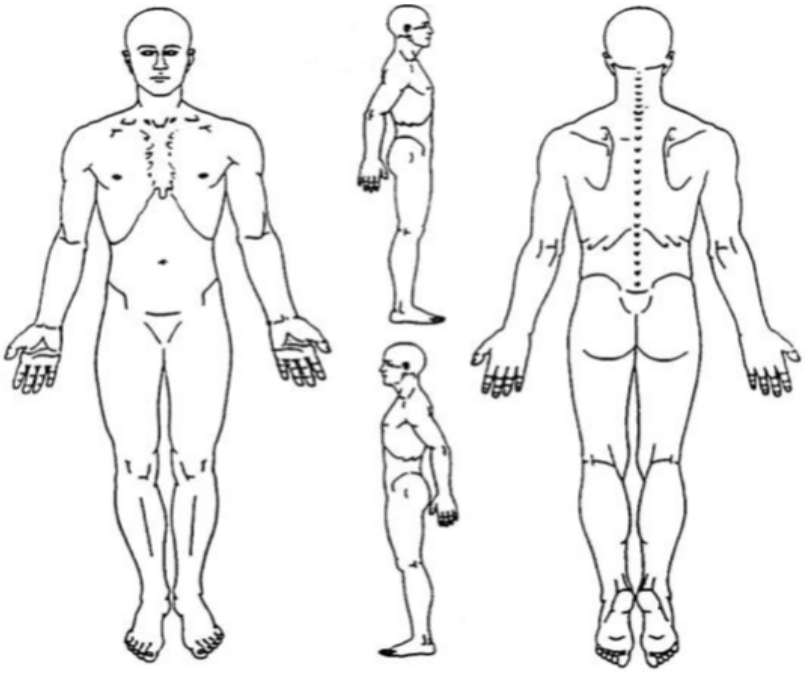
List any diagnostic tests that have been performed that are related to your current condition (i.e. MRI, X-ray, etc) Please make sure to include the date each test was performed.

Diagnostic Test	Date

List current medications or supply a printed list to the registration clerks. If a list is already on file, please inform the clerks so that they can make sure it is transferred to your therapy case.

Medication List	Medication List

Please indicate on the body chart where your symptoms are located by circling the affected area(s):



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GENDER IDENTITY OR EXPRESSION

Federal non-discrimination law (Section 1557) requires all health care facilities to treat individuals consistent with their gender identity or expression. FLOYD, in compliance with these federal laws, will need you to respond to the following questions:

For clinical reasons, We need to know your sex at birth. Please choose one: ☐ Male ☐ Female

What is your preferred form of address? Check one answer below

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____

The federal government requires all hospitals, which includes Floyd Medical Center, to ask each of our hospital patients to provide answers to the questions below. These questions relate to your race and ethnicity. The answer you provide will then be reported by Floyd Medical Center to the federal government as required.

What is your race? ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ White ☐ Alaska Native
☐ Black or African American ☐ Pacific Islander ☐ Other _____

What is your ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is your preferred language? ☐ English ☐ Spanish Other _____

* How did you hear about our facility? _____

Patient Signature: _____ Date AND Time: _____

Staff Signature: _____ Date AND Time: _____