Starr Regional Medical Center
Patient Summary List
Please check all that apply

Past Medical History

- ☐ Hypertension (High Blood Pressure)
- ☐ Hypotension (Low Blood Pressure)
- ☐ Myocardial Infarction (Heart Attack)
- ☐ CHF
- ☐ Heart Disease
- ☐ Heart Arrhythmias
- ☐ CVA, TIA (Stroke)
- ☐ Traumatic Brain Injury/Closed Head Injury
- ☐ COPD
- ☐ Asthma
- ☐ Thyroid Dysfunction
- ☐ Tuberculosis
- ☐ Apnea
- ☐ Diabetes
- ☐ Cancer: Specify _____ Year _____
- ☐ Parkinson's
- ☐ Anxiety/Depression/Other_____
- ☐ Other: _____
- ☐ RA/OA (Please Circle)
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Osteoporosis/osteopenia
- ☐ DJD (Degenerative Joint Disease)
- ☐ DDD (Degenerative Disc Disease)
- ☐ Lupus
- ☐ DVT
- ☐ Autism
- ☐ Prematurity
- ☐ Seizure Disorders / Epilepsy
- ☐ Spina Bifida
- ☐ Developmental Delay
- ☐ ADD / ADHD (circle)
- ☐ Down's Syndrome
- ☐ Cerebral Palsy

Surgical History

- ☐ Pacemaker
- ☐ Amputation
- ☐ Cervical
- ☐ Back/Spine
- ☐ CABG/Stents (Please Circle)
- ☐ Hysterectomy
- ☐ Orthopedic: Specify_____
- ☐ Tubal Ligation
- ☐ Other: _____
- ☐ Abdominal: Specify _____
- ☐ Appendectomy (Appendix)
- ☐ Carpal Tunnel
- ☐ Bowel Resection
- ☐ Cholecystectomy (Gallbladder)
- ☐ Mastectomy
- ☐ Tonsillectomy
- ☐ **None**

List known drug allergies and the reactions: _____

_____

My goals for therapy include: _____

_____

I, _____, give my consent for the Rehabilitation Department of Starr Regional Medical Center to provide rehabilitation services as ordered by my physician. I have been informed of my treatments and plan of care and hereby give consent for treatment. I understand that it is my responsibility to inform the rehabilitation department of my complete medical history and to keep them informed of any changes in my medical condition and/or medication regimen to ensure continuity of care. Failure to do so could result in an inappropriate treatment program.

I understand that cancellations and "no shows" interfere with the rehabilitation team's ability to be productive and to serve all their patients. I understand that cancellations also will hinder my progress in therapy. If I have **2** "no shows" without contacting the department, I will be discharged and my physician will be contacted regarding my noncompliance.

_____ _____

Patient Signature **Date**