

Does the patient have any of the following? Advance Directive Living Will Medical Power of Attorney DNR
 Copy provided: Initials: _____ Date: _____ Time: _____

Referring Physician : Phone: _____ Fax: _____	Primary Care Physician: Phone: _____ Fax: _____
ALLERGIES – REACTION:	

Past Medical History: Do you have ANY previous history of the things listed below?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
High Blood Pressure			Pacemaker		
Heart Condition			Seizures		
Stroke(s)			Cancer		
Metal Implants			Shortness of Breath		
Diabetes			Persistent Night Pain		
Dizziness			Frequent/Severe Headaches		
Light Headedness			Unexplained Weight Loss		
Excessive Fatigue			Past or Current Bowel/Bladder dysfunction		
Broken Bones (fractures)			Gynecological Issues		
Fibromyalgia			Vaginal/Cesarean Birth (Number: _____)		
Arthritis			↳ Did you have any back pain with your pregnancy or after childbirth?		

Initials	Date	Time	OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS?

Initials	Date	Time	PREVIOUS PROCEDURES / SURGERIES?	Date Performed

Initials	Date	Time	CURRENT MEDICATIONS, INCLUDING HERBALS

INITIALS	SIGNATURE	INITIALS	SIGNATURE

09.0109




Olathe Medical Center
 20333 West 151st Street
 Olathe, Kansas 66061

**REHABILITATION
 SERVICES OUTPATIENT
 SUMMARY**

Page 1 of 2

8.22.2011; Rehab; md **O.M.C. No. 1948**

PLACE
 PATIENT LABEL
 HERE

