IRCP Medical History Form

Today's Date:_____

Name _____

Address _____

_____

Cell Phone_____ Home Phone_____

Referring Physician's Name/Address/Phone/Fax: _____

_____

Primary Care Physician's Name/Address/Phone/Fax:_____

_____

Emergency Contact's Name, Relationship to you, Address and Phone: _____

_____

****

Age_____ Date of Birth_____

When were you diagnosed with Polio?_____

How long were you hospitalized initially?_____

Did you use an iron lung? _____For how long? _____

Did you have any breathing or swallowing problems with the initial polio?_____

Did you wear braces initially? If so, what kind?_____

_____

When did you stop wearing braces or switch to something else (give details)?_____

_____

Approximately when did you first notice new problems?_____

_____

Do you have new weakness (give details)?_____

_____

Do you have pain (give details)?_____

_____

Do you have fatigue (give details)?_____

_____

Do you have new muscle atrophy?_____

Do you have new swallowing problems?_____

Do you have new breathing problems?_____

Are you sensitive to cold?_____

Have you had any falls in the last 12 months?_____

How many?_____

Have you had any injuries from falls that required medical treatment?_____

_____

_____

Do you require the use of any assistive devices (ie: cane, crutches, bracing, wheelchair, etc.)? Please list.

_____

_____

_____

Have you had any of the following? (Please list dates and where studies were done)

X-rays_____ Area of the body:_____ Date:_____ Facility:_____

MRI_____ Area of the body:_____ Date:_____ Facility:_____

Bone Scan: _____ Area of the body:_____ Date:_____ Facility: _____

CT Scan_____ Area of the body:_____Date:_____ Facility:_____

EMG_____ Area of the body:_____Date:_____ Facility:_____

Bone Mineral Density _____ Date:_____ Facility:_____

Sleep Study_____ Date:_____ Facility:_____

If possible, please try to obtain copies of these reports prior to your appointments. Only those studies done within the last five years are necessary.

Please list your medications, frequency and dosage:

_____

_____

_____

_____

Do you have any allergies to medications?_____

_____

Please list any current medical problems:_____

_____

_____

_____

List any surgeries you have had in the past:_____

_____

_____

_____

Do any significant medical conditions run in your family?_____

_____

_____

Are you currently receiving home care?_____

*If yes, what are you being treated for?_____

*Please be aware that if you have Medicare for your insurance, any home care (i.e. VNA PT/OT/Speech, Nursing, Home Health Aide) must be completed at least 30 days prior to your appointments at our center. If not, Medicare will not pay for these services.

Are you interested in meeting with our registered dietician?_____

Describe the home you live in (e.g., how many steps to enter, how many levels, etc.)

_____

_____

_____

Who else lives with you?_____

Do you work (give details)?_____

Do you smoke cigarettes?_____ How many per day?_____ How long have you smoked?_____

How much alcohol do you drink daily?_____

Are you right hand or left hand dominant? (circle one) RIGHT LEFT BOTH

What would you like us to help you with the most?

_____

_____

_____

_____

_____

_____

Do you have a family history of heart disease?	YES	NO
Do you have a family history of diabetes?	YES	NO
Do you have a family history of arthritis?	YES	NO
Do you have any significant family illness history?	YES	NO
Have you ever had cancer?	YES	NO
Have you ever had a seizure?	YES	NO
Have you had recent fever or weight loss?	YES	NO
Do you have a history of eye problems?	YES	NO
Do you have a history of ear, nose, mouth or throat problems?	YES	NO
Do you have history of respiratory problems?	YES	NO
Do you have a history of gastrointestinal problems?	YES	NO
Do you have a history of genitourinary problems?	YES	NO
Do you have a history of musculoskeletal problems?	YES	NO
Do you have a history of neurological problems?	YES	NO
Do you have a history of psychiatric problems?	YES	NO
Do you have a history of thyroid problems?	YES	NO
Do you have a history of allergies or immunologic problems?	YES	NO
Do any diseases run in your family?	YES	NO

If YES, please explain: _____

_____

Insurance information

Please make sure all applicable information is supplied

YOUR NAME:

YOUR SOCIAL SECURITY NUMBER:

INSURANCE SUBSCRIBER'S NAME:

NAME OF INSURANCE COMPANY:

CLAIMS DEPARTMENT ADDRESS:

YOUR CARD NUMBER/ ID NUMBER:

CUSTOMER SERVICE PHONE NUMBER:

REFERRAL OR AUTHORIZATION NUMBERS RECEIVED:
(If applicable. You may request these referrals **after** your appointments are scheduled)

NAME OF PERSON YOU SPOKE TO FOR AUTHORIZATION:

OTHER INSURANCE INFORMATION:

How did you hear about the IRCP?

___Referred by doctor
___Friend
___Internet
___From an article in:_____
___Post polio support group
___Attended a lecture
___Other:_____

Please return completed form to: International Rehabilitation Center for Polio
570 Worcester Road
Framingham, MA 01702
Fax: (508) 872-1205