RSI-Rehabilitation Services, Inc. MEDICATION & SURGICAL HISTORY

Date: _____ Patient Name: _____ DOB: _____

Allergies

Name of Substance (food or drug)	Type of Reaction
□ Check if none	

Current Medications

Name of Prescription Drugs (such as Atenolol, eye drops, ointments, etc.)	Strength (e.g., 5 mg) Check if unknown		Directions (such as 1 tablet twice a day). Check box if taken only as needed		Name of provider who prescribed the medication
□ Check if none		□		□	
		□		□	
		□		□	
		□		□	
		□		□	

Name of Over-the-Counter Medications (such as ibuprofen)	Strength	Directions (such as "take as needed for pain")
□ Check if none		

Name of Herbs, Vitamins, Minerals, etc. (such as Glucosamine)	Strength	Directions (such as "one per day")
□ Check if none		

History of Surgeries

Type of Surgery (e.g., hip replacement)	Approximate Date of Surgery	Surgeon / Hospital	Outcomes / Comments
□ Check if none			

Medical Episodes or Diagnoses

Medical Episode or Diagnosis (e.g., Autism, Stroke)	Date of Onset or Diagnosis	Name of Physician following your care	Comments
□ Check if none			

Additional info: _____