PT-RN CARE, INC
Progress Thru Rehabilitation and Nursing Care

Medical Record#: _____ Today's Date: _____

Patient's Name: _____ Age: _____ Gender: □ Male □ Female

Address: _____ _____ _____ _____ _____
(*street*) (*apt/suite/bldg*) (*city*) (*state*) (*zip code*)

Birth Date___/___/____ Tel.No: (_____) - _____-_____ Physician: _____
(*mo / day / year*)

Date of Rx: _____ End or Cert: _____ SOC: _____ Date of Onset: _____

State ID # / State Driver's License #: _____ Social Security Number: _____

Medicare #:_____ □ Part A: Effective Date: _____ Expiration Date: _____

□ Part B: Effective Date: _____ Expiration Date: _____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

EMERGENCY CONTACT NUMBER: _____

Secondary Insurance: _____ Effective Date: _____ Expiration Date: _____

Tel. # of Secondary Insurance: _____ ID#:_____ Claim#:_____

Name on Policy: _____ Policy#: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.
(POR FAVOR CONTESTE LAS SIGUIENTE PREGUNTAS LO MEJOR QUE PUEDE.)

1. **LIST OF MEDICATIONS YOU ARE TAKING NOW AND WHAT IS IT FOR.**
   (LISTA DE MEDICACIONES QUESTA TOMANDO EN ESTE MOMENTO Y PARA QUE SON.)
   □ **YES***(SI)* □ **NO** *(NO)*_____
   _____
   _____

2. **DO YOU HAVE A HISTORY OF CANCER? IF YES, WHEN WAS IT DIAGNOSED AND WHAT BODY PART.**
   (TIENE CANCER? Y SI, CUANDO FUE SU DIAGNOSTICO, Y QUE PARTE DEL CUERPO FUE.)
   □ **YES***(SI)* □ **NO** *(NO)*_____

3. **DO YOU HAVE HYPERTENSION?** □ **YES***(SI)* □ **NO** *(NO)*
   (TIENE ALTAPRESSION?)

4. **DO YOU HAVE A HISTORY OF HEART DISEASE?** □ **YES***(SI)* □ **NO** *(NO)*
   (TIENE PROBLEMAS DEL CORAZON?)

5. **HAVE YOU EVER HAD A STROKE? IF YES, WHEN?** □ **YES***(SI)* □ **NO** *(NO)*
   (Y SI, CUANDO FUE?)

6. **DO YOU HAVE A PACEMAKER?** □ **YES***(SI)* □ **NO** *(NO)*
   (TIENE UN MARCA PASOS?)

7. **DO YOU HAVE A HISTORY OF DIABETES?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
   (TIENE DIABETES?)
8. **DO YOU HAVE DIFFICULTY BREATHING?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
   (TIENE PROBLEMAS AL RESPIRAR?)
9. **DO YOU HAVE SEVERE HEADACHES:** ☐ **YES***(SI)* ☐ **NO** *(NO)*
   (LE DAN DOLORES DE CABEZA?)
10. **DO YOU HAVE DIZZY SPELLS?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    (LE DAN MAREOS?)
11. **DO YOU HAVE EYE PAIN OR VISION PROBLEMS?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    (TINE DOLOR EN LOS OJOS O PROBLEMAS DE SU VISTA?)
12. **DO YOU HAVE HISTORY OF SEIZURE OR EPILEPSY?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    (TIENE HISTORYA DE EPILEPSIA O ATAQUES?)
13. **DO YOU HAVE ANY ALLERGIES? IF YES, WHAT.** ☐ **YES***(SI)* ☐ **NO** (*NO)*
    (*TIENE ALLERGIA? Y SI, QUE SON?)*
14. **DO YOU HAVE ANY METAL PINS OR PLATES IN YOUR BODY?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    (TIENE METAL O PLACAS EN SU CUERPO?)
15. **DO YOU HAVE ANY TINGLING OR NUMBNESS SENSATIONS?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    IF YES, WHERE?
    (SIENTE ALGUNA PARTE DE SU CUERPO ENTUMIDA O HORMIGUEO? Y SI DONDE?)
16. **DO YOU HAVE DIFFICULTY WALKING?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    (TIENE PROBLEMAS CUANO CAMINA?)
17. **DID YOU HAVE SURGERY BEFORE?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    IF YES, WHEN AND WHERE.
    (A TENDIDO SIRUGIA ANTES? Y SI, CUANDO Y DONDE?)
18. **ARE YOU PREGNANT OR POSSIBLY PREGNANT?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    (A ESTADO EMBARAZADA O ES POSIBLE QUE ESTA EMBARAZADA?)
19. **DO YOU HAVE AIDS/HIV?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
20. **DO YOU HAVE ANY COMMUNICABLE DISEASES?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
21. **DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT ASK IN THIS QUESTIONNAIRE THAT WE NEED TO KNOW?** ☐ **YES***(SI)* ☐ **NO** *(NO)*
    IF YES, WHAT ARE THEY? _____
    _____
    _____
22. **ARE YOU UNDER THE CARE OF ANY DOCTOR?** ☐ **YES***(SI)* ☐ **NO** *(NO)*