



Have you had or do you have any of the following? Check **YES** or **NO** after each question.

Disease of:	Yes	No	Symptoms/Illness	Yes	No	Symptoms/Illness	Yes	No	Symptoms/Illness	Yes	No
Back (spine)			Alcoholism			Dizziness			Nervous breakdown		
Bladder			Anemia			Draining Ears			Palpitations		
Bone			Arthritis			Drug Abuse			Paralysis		
Brain			Asthma			Encephalitis (sleeping sickness)			Pleurisy		
Ears			Back injury			Eye injury or defect			Pneumonia		
Eyes			Backaches			Fainting spells			Poor appetite/weight loss		
Gallbladder			Black or bloody bowel movements			Foot trouble			Rectal disease		
Genitals			Blood in urine			Frequent colds			Recurrent nausea		
Heart			Broken bones or joint problems			Frequent headaches			Recurrent vomiting		
Intestines			Bronchitis			Frequent or painful urination			Rheumatic Fever		
Joints			Cancer or tumors			Frequent sore throat			Rheumatism		
Kidneys			Chest pains			Gonorrhea			Seizures or convulsions		
Liver			Chronic constipation			Hemorrhoids			Shortness of breath		
Lungs			Chronic cough			Hernia (rupture)			Skin trouble		
Lymph nodes			Chronic indigestion			High blood pressure			Spina Bifida		
Nose			Chronic sinus infection (hay fever)			Jaundice			Stomach ulcers		
Skin			Coughing up blood			Kidney stones			Swollen ankles		
Spleen			Deafness			Knee injury			Syphilis		
Stomach			Depression			Malaria			Tuberculosis		
Throat			Diabetes			Nephritis			Varicose Veins		
									Vomiting of blood		

Domestic violence is a common health problem in the United States. Therefore, it is our responsibility to assess all patients for the presence of potential domestic violence in their lives. **Please respond to the following question: Do you feel safe at home? Yes No**

Have you fallen in the last 30 days?

Surgeries:

Do you have any implants? (pacemaker, joint replacement, medicine pump, etc.) Please list all implants:

Other hospitalizations? If yes, please give details.

Serious illness not requiring hospitalization:

Are you presently under a doctor's care? If yes, please explain.

Are you presently pregnant or trying to become pregnant?

Do you have any disability that may affect your ability to participate in your medical treatment?

The preceding information is true and complete. I understand that any mis-statement or omission may affect the outcomes of my health care or the care for the person for which I am signing.

Signature of Patient or Guardian

Date

Witness Signature

Date

#0000009884 Gate 8/11

Chart Copy

**Brazosport Regional Outpatient Rehabilitation Services: Health History**



**Brazosport**  
REGIONAL HEALTH SYSTEM

100 Medical Drive Lake Jackson, TX 77566

Patient ID

## Advance Directives and Out of Hospital DNR Questionnaire

Healthcare decisions can sometimes be very difficult, especially if you are unable to make those decisions for yourself. An Advance Directive is a way for you to state your wishes, and you may also designate someone to make decisions for you. We think of it as advance care planning.

Do you have an Advance Directive (Medical Power of Attorney or Living Will)?	Yes	No
If yes, is the document on file with Brazosport Regional Health System?	Yes	No
Do you have an Out of Hospital DNR?	Yes	No
Would you like additional information on Advance Directives or DNR's?	Yes	No

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Signature of Patient/Guardian

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Date

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*For office use only:*

*Advance Directive Packet given? Yes No*

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