CASE HISTORY FORM

Department of Rehabilitation and Physical Medicine, Na Homolce Hospital

NA HOMOLCE NEMOCNICE

Surname and name, degree: Birth Certificate no.:	PID
Profession: Sick leave ☐ yes ☐ no Tel./e -mail: Height (cm): Weight (kg):	

Please, complete following data (tick the box ☐ with X, write in free space here or on the other page):

Cardiac pacemaker		☐ yes	☐ no
Bleeding disorders, taking medications for blood dilution. State them::		☐ yes	☐ no
Neoplastic disease. State:		☐ yes	☐ no
Metallic elements in your body. What and where:		☐ yes	☐ no
Endocrinology diseases: thyroid, adrenal glands, hypothalamus, hypophysis (pituitary bland), pancreas (diabetes)… State:		☐ yes	☐ no
Neurological diseases (cerebrovascular accident, multiple sclerosis, myasthenia, epilepsy,…). State:		☐ yes	☐ no
Women: Date of last period:	Are you pregnant? ☐ don't know	☐ yes	☐ no
Heart diseases (aneurysm, congenital heart disease, ischaemic heart disease, heart rhythm disorder) State:		☐ yes	☐ no
High blood pressure		☐ yes	☐ no
Vascular disease (peripheral artery disease, inflammation of a vain, varicose ulcer, varix, thrombosis, …). State:		☐ yes	☐ no
Respiratory system disease. State:		☐ yes	☐ no
Rheumatological disease. State:		☐ yes	☐ no
Gastrointestinal disease (liver, pancreas, ulcerative colitis…) State:		☐ yes	☐ no
Glaucoma		☐ yes	☐ no
Skin disease (eczema, skin formation …). State:		☐ yes	☐ no
Psychiatric disease. State:		☐ yes	☐ no
Injuries, surgeries. Give the type and date:		☐ yes	☐ no
Do you use medications? Which ones:		☐ yes	☐ no
Other diseases. State:		☐ yes	☐ no
Are you allergic? State the type of allergy (mainly to medications!):		☐ yes	☐ no

Please, continue on the other page → → →

Please, state the information related to your visit to the Department of Rehabilitation and Physical Medicine:

What is a reason of your visit?	
I have problems	□ After injury (state) :_____ □ After surgery (state): _____ □ Other reasons (state): _____
Duration of problems	□ 1-7 days □ 1-3 weeks □ 3-9 weeks □ 2–3 months □ 3-7 months □ 7–12 months □ longer – state how long:
What would I like to achieve with rehabilitation?	

If disease treatment takes place outside the NNH, bring the medical reports for the examination by a rehabilitation doctor!

Current level of pain - chose a number on the scale corresponding to the intensity of your pain:

No pain										Highest possible pain
0	1	2	3	4	5	6	7	8	9	10

Which activities are reduced by your health problems/pain at most:

In case of injuries and locomotor system surgeries state the limitations expressed by another specialist (orthopaedic surgeon…) E.g. in case of lower limbs surgery state a level of permissible loading of an operated limb when standing (in % or in kg, etc.), scope of permissible movement in the affected joint …

Space for additional information:

Date of completion:…… Patient signature ……..

(confirms the truth and completeness of information)

Patient insurance with the commercial insurance company.

If the commercial insurance company asks the attending rehabilitation doctor for the information on the nature of disease and the treatment plan, I express my agreement to provide such information with my signature. .

In Prague, date: …… Patient signature: ……