Onslow Memorial Hospital
REHABILITATION SERVICES

PATIENT MEDICAL HISTORY FORM

Home Health Services: Do you currently have a ***therapist*** or ***nurse*** that comes to your home? ___ Y ___ N
If YES, you will be unable to qualify for outpatient therapy

Physician Who Ordered Therapy: _____

Living Situation: □ live alone □ with spouse □ family member(s) Do you have stairs? □ yes □ no ____# of stairs

WORK STATUS: Occupation: _____ Employer: _____

Type of shift: □ Full-time □ Part-time □ Light Duty □ Out of work due to injury/condition □ Retired

GENERAL HEALTH STATUS: (please check all that apply)

Dominant Hand: □ right □ left Vision: □ good □ need glasses Hearing: □ good □ hearing aid Known Allergies? : □ Yes □No (list): _____ _____ Are you pregnant? □ yes □ no Precautions:_____	□ arthritis € joint pain □ asthma / breathing problems □ cancer _____(type) □ depression □ diabetes □ osteoporosis □ heart condition □ high blood pressure □ high cholesterol □ history of past stroke	□ metal implants □ pacemaker □ recent weight gain / loss □ reflux / heart burn □ seizures □ swallowing problems □ urinary incontinence □ drug / alcohol dependent □ use tobacco products; # yrs _____ □ other:_____

Past surgeries or conditions: _____

CURRENT CONDITION: Describe problem for which you are seeking therapy:
_____

How did this condition begin? _____

Date condition began: _____ Hospitalized? □ yes □ no; for how long?_____ where?_____

Have you had therapy for it before now? □ yes □ no; for how long?_____ what type? PT OT ST OTHER _____

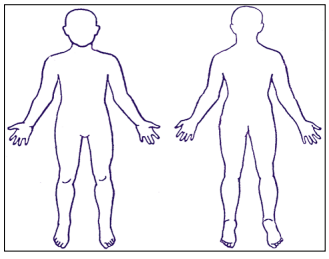
Have you had surgery or any other treatment for this condition? If yes, describe:_____

What tests, including x-rays, have been done for this condition?_____

Mark the area of your body affected

Are you having pain? □ yes □ no; describe location, frequency and type of pain below:

_____



If in pain, please rate:

0	1	2	3	4	5
No Pain	Mild	Moderate		Severe	Excruciating

What helps your pain?_____ What makes your pain worse?_____

List all current medications, herbal supplements and over-the-counter meds: _____

_____
_____

STICKER

Patient or Guardian Signature / Date