## MEDICAL HISTORY FORM

## OUTPATIENT REHABILITATION SERVICES

**Home Health:** Do you currently have a therapist or nurse that comes to your home? __N __Y **(if yes, return to window)**

Physician who ordered therapy: _____

**Living Situation:** ___live alone ___with spouse ___family members Do you have stairs? __yes __no _____#

**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<br>Hand: __right __ left<br>Vision: __good __ need glasses<br>Hearing: __good __ hearing aid<br>Known Allergies? __ Yes __ No<br>(list)<br>:<br>_____<br><br>Are you pregnant? __yes __no<br><br>Precautions: _____ | __ arthritis /joint pain<br>__ asthma / breathing problems<br>__ cancer<br>_____(type)<br>__ depression<br>__ diabetes<br>__ osteoporosis<br>__ heart condition<br>__ high blood pressure<br>__ high cholesterol<br>__ history of past stroke | __ metal implants<br>__ pacemaker<br>__ recent weight gain / loss<br>__ reflux / heart burn<br>__ seizures<br>__ swallowing problems<br>__ urinary incontinence<br>__ drug / alcohol dependent<br>__ use tobacco products<br>* years of smoking: _____<br>other: _____ |

Past surgeries or conditions: _____

**CURRENT CONDITION:** 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

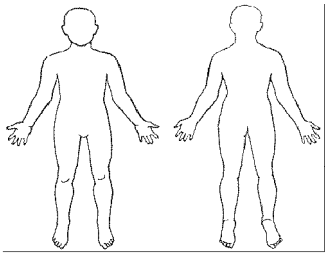
Have you had surgery or any other treatment for this condition? If yes, describe: _____

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

Are you having pain? __yes __no; describe location, frequency and type of pain below:

_____

**Mark areas of your body affected**



If in pain, please rate:

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| No Pain | Mild | | Moderate | | Severe |

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

List all current medications: _____

_____

_____

**Patient or Guardian Signature / Date**