OUTPATIENT REHAB MEDICAL HISTORY

MASONIC HOMES of KENTUCKY

Your Name: _____ Date: _____

Emergency Contact: _____ Telephone #: _____

Family Physician: _____ Telephone #: _____

Special Learning Needs:_____ Please Explain: _____

Date of Injury: _____

Why are you here? _____

_____

_____

Your Medical Information (Check all that apply)

Hypertension (high blood pressure) ❒
Hypotension (low blood pressure) ❒
Pacemaker ❒
Emphysema/Asthma ❒
Bleeding/Bruising (recent history) ❒
History of diabetes ❒
Hypoglycemia ❒
Cancer/Tumors/Growths ❒
Active seizure disorder ❒
Osteoporosis ❒
Swelling of extremities ❒
Fractures? ❒
Date_____ Area_____
Date_____ Area_____
Artificial joints ❒
Light-headness/Dizziness ❒
Anxiety/Panic attacks (recent) ❒
Depression (recent) ❒
Alzheimer's ❒

Shortness of breath ❒
Chest pain/Angina/Heart attack ❒
Urinary urgency/Incontinence ❒
Are you pregnant? ❒
History of pressure sores ❒
Are you in pain? ❒
If in pain, where? _____
_____

Have you had/have:

Stroke ❒
Brain injury ❒
Multiple sclerosis ❒
Spinal cord injury ❒

If you checked any of these boxes, are you under a physician's care for any of these conditions?

Yes ❒ No ❒

List any allergies: _____

List surgeries within the last 12 months (include dates): _____

_____

_____

What are your treatment goals? _____

_____

_____

MASONIC HOMES of KENTUCKY

Your Fall Assessment (Check all that apply)

Have you fallen within the past year?	❒	How many times? _____
Falls within past year resulted in injury?	❒	
Are you are afraid of falling?	❒	
Feel unsteady on your feet or in wheelchair?	❒	
Experience dizziness or vertigo?	❒	
Have vision problems not corrected by glasses?	❒	
Use sedatives that affect your alertness during the day?	❒	
Have memory/cognitive difficulties?	❒	
Have lower extremity disability that affects walking?	❒	

Your Medications (List below)

_____

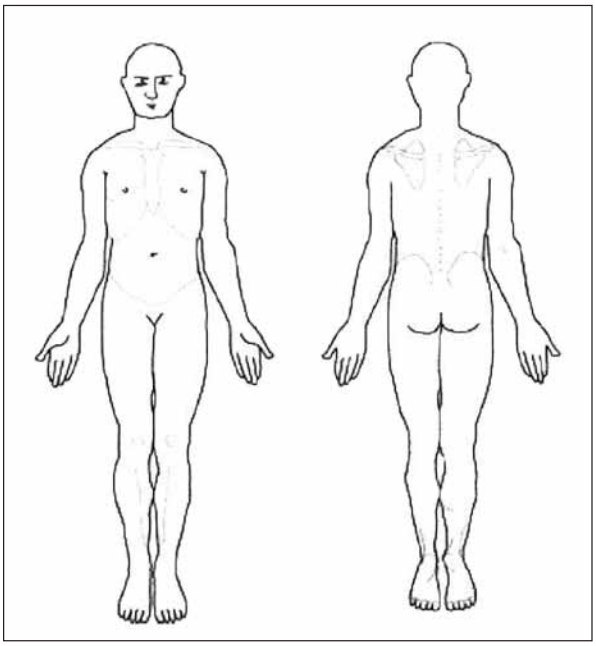
_____

_____

What Are Your Symptoms?

Localize areas of pain or abnormal sensation on the body chart below.

(Shade in where appropriate)



Rate Your Pain

Mark **X** below to rate your pain at rest and **O** to rate your pain with activity.

1 Minimal Pain

5

10 Extreme Pain

_____ _____

Your Signature Date

Relationship to patient if patient is a minor _____