OUTPATIENT REHAB
MEDICAL HISTORY

MASONIC HOMES KENTUCKY

Patient name: _____ Date: _____

Emergency contact: _____

Phone: _____

Family physician: _____

Phone: _____

Special learning needs: _____

Please explain: _____

Date of injury: _____

Why are you here? _____

_____

_____

Your Medical Information

- ☐ 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? (check if yes)
- ☐ History of pressure sores
- ☐ Are you in pain? (check if yes)

  If in pain, where? _____

Height: _____

Weight: _____

Have you recently traveled out of the country?

☐ Yes ☐ No

Have you had direct, prolonged contact with a person that is confirmed positive for COVID-19?

☐ Yes ☐ No

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 details): _____

_____

_____

_____

What are your treatment goals? _____

_____

_____

_____

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 Home

With whom do you live? ☐ Alone
☐ Spouse only ☐ Spouse and others
☐ Child ☐ Other

Where do you live? ☐ Private home
☐ Apartment/rented room
☐ Assisted living/group home ☐ Other

Does your home have?
☐ Stairs, no railing ☐ Stairs, railing
☐ Ramps ☐ Uneven terrain

Your Medications (List below both prescribed and over the counter medications)

_____

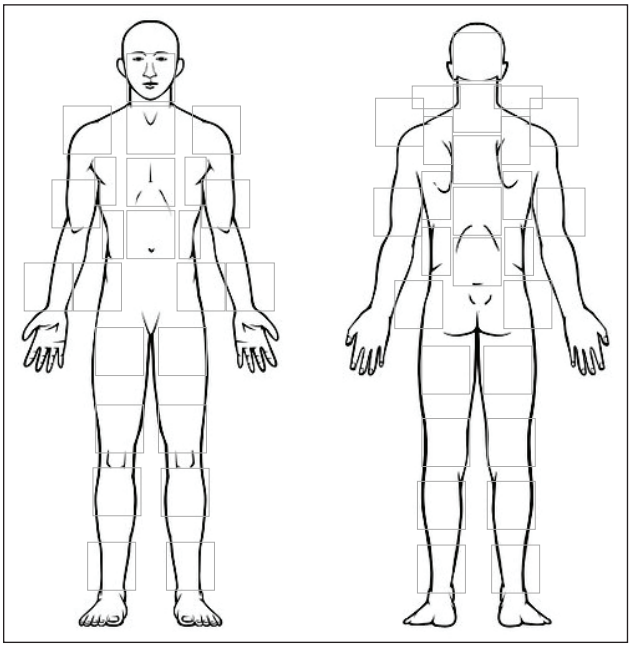
_____

_____

_____

Where is your pain?

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.

Current pain level

1 Minimal Pain — **5** — **10** Extreme Pain

Pain level at best

1 Minimal Pain — **5** — **10** Extreme Pain

Pain level at worst

1 Minimal Pain — **5** — **10** Extreme Pain

To the best of my knowledge this information is accurate and complete.

Signature: _____

Date: _____

Relationship to patient if patient is a minor: _____