OCONEE Medical Center

Rehabilitation Services Adult Patient History Questionnaire

All information will remain confidential

Patient name: Date of Birth: / / ☐ Male ☐ Female Date: Time:				
At times we may need to contact you by phone. May we leave a telephone message for you? ☐ Yes ☐ No				
Home Phone: Cell Phone: Work Phone:				
Height: Weight: Primary Language: ☐ English ☐ Spanish ☐ Other:				
Primary Care Physician: Referring Physician:				
Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No				
Please describe the problem for which you were referred to therapy.				
When did it happen?	How did it happen?			
Did you have surgery for it?	If so when did you have surgery?			
Have you had therapy for it?	If so where did you have therapy?			
Have you had any tests? X-ray, MRI, CT Scan, MRI, EMG Where were these tests done?				
Please rate your currently level of activity. 0 equals no activity (bed bound) and 10 equals pre-injury or symptom activity level. 1 2 3 4 5 6 7 8 9 10	Please rate your currently level of pain (the pain you are having right now).0 equals no pain and 10 equals pain requiring emergency care 1 2 3 4 5 6 7 8 9 10			
What are your goals of therapy?				
When will you follow up with the physician who referred you to therapy?				
Please list ALL medications you currently take including over the counter and herbal supplements.				
Do you have any allergies to any:	**Yes**	**No**	**Unknown**	**Reaction**
Medications? (list):				
Foods? (banana, kiwi, avocado, tomato):				
Latex ?(sneakers, balloons, rubber cause itching or wheezing)?				
General Lifestyle questions				
Are you currently able to work				Occupation:
Do you exercise regularly?				Low moderate active
Do you have shortness of breath after walking up 2 flights of stairs?				
Do you smoke?				#packs/day___#years___
Are you an ex-smoker? When did you stop?				
Do you use oxygen at home?				How many liters ____
Do you drink alcoholic beverages?				How much___ how often___
Do you use street drugs?				
Do you have problems with pain? (please describe) Where do you have pain? When do you have pain? What makes it better? What makes it worse?				
Females Only-Is there any chance you could be pregnant? Any children? Last Menstrual Period:_____				Number of births_____

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Health Conditions-*Check all that apply:* **(WNL means, "Within Normal Limits")**

Skin □WNL □ Rashes □ Sore/Open areas □ Edema/Lymphedema **Breast** □WNL □ Lumps □ Nipple Discharge **Cancer or Tumor** □WNL □ Type:_____	**Hearing and Vision** □WNL □ Hearing loss □ Hearing Aide □ Glasses □ Contacts □ Glaucoma □ Cataract	**Respiratory** □WNL □ Asthma □ Bronchitis □ Difficulty Breathing □ Emphysema □ Hoarseness □ Pneumonia □ Sleep Apnea □ TB	**Cardiac** □WNL □ Chest Pain □ Congestive Heart Failure □ Heart Disease □ High Cholesterol □ High Blood Pressure □ Pacemaker/ICD □ Rheumatic Heart □ Rhythm disturbances
Bleeding Circulation □WNL □ Anemia □ Bleeding tendency □ Blood Clots □ Poor circulation □ Sickle Cell Anemia □ Transfusion of blood/plasma	**Gastrointestinal** □WNL □ Recurrent Gastric Reflux □ Hernia □ Ulcers □ Difficulty swallowing	**Genitourinary** □WNL □ Kidney disease □ Kidney stones □ Prostate/testicle problem □ Urinary Tract Infection □ Difficulty urinating	**Endocrine** □WNL □ Diabetes. Controlled by: Circle: *Diet / Pill / Insulin* □ Hepatitis □ HIV Positive □ Liver disease □Thyroid Problems/ Goiter □ Adrenal disease
Musculoskeletal □WNL □ Arthritis □ Limited movement □ Multiple Sclerosis □ Muscular Dystrophy □ Back/neck problems □ Polio	**Neurological/Mental Health** □ Stroke □WNL □ Stroke Mini (TIA) □ Seizures □ Migraine Headaches □ Chemical dependency □ Myasthenia Gravis □ Depression/Anxiety □ Emotional Illness □ Learning Disabilities	**Infectious Diseases** □WNL □ Recent Mono □ HIV □ Hepatitis A, B, C □ MRSA Location:_____ □ VRE □ C. diff	**Implantable Devices** □WNL □ Ports/Pumps □ Other (list):_____ _____ _____
Please list all hospitalizations and explain:			

Surgical History: (Check all that apply)

□ **No Prior Surgery** □ Angioplasty □ Appendectomy □ Arthroscopy □ Breast Biopsy □ Heart Bypass	□ Cataract □ D and C □ Gallbladder □ Heart Cath □ Heart Valve replaced	□ Hemorrhoidectomy □ Hernia □ Hysterectomy □ Kidney removal □ Mastectomy Left/Right □ Pacemaker	□ Prostate □ Spine (Back/Neck) □ Splenectomy □ Tonsils and Adenoids □ Total Hip Left / Right □ Total Knee Left/Right	□ Tubal Ligation List any other: _____ _____ _____

Family History (close blood relatives): (Check all that apply)

□ Heart disease □ High Blood Pressure	□ Diabetes □ Tuberculosis	□ Cancer □ Kidney disease	□ Thyroid disease □ Blood disease	□ Neurological □ Mental Illness

List any Religious or cultural practices we should know about while caring for you:

If filled out by Patient: *Patient Signature*:	Date:	Time:
If filled out by Patient Representative: *Signature*:	Date:	Time:
Representative's Relationship to Patient:		