

SAINT PETER'S UNIVERSITY HOSPITAL
PHYSICAL MEDICINE AND REHABILITATION DEPARTMENT

Name (Printed): _____

Date: _____

Please check or circle all appropriate boxes. All information will be kept strictly confidential.

Pertinent Medical History	Yes	No	Comments	Current Health	Yes	No	Comments
1. Heart Disease Heart attack Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____	1. Weakness in arms Weakness in legs Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. High blood pressure				2. Weight loss / gain			
3. Diabetes				3. Tiredness / fatigue			
4. Cancer				4. Nausea / vomiting			
5. Kidney / bladder problems				5. Fever / Chills / Sweats			
6. Liver problems				6. Dizziness/light-headed/headaches			
7. Thyroid problems				7. Numbness / tingling			
8. Prostate problems				8. Bowel / urinary problems			
9. Stroke / TIA				9. Joint / bone pain			
10. Circulation problems				10. Night pain			
11. Osteoporosis				11. Chest pain / heart palpitations			
12. Blood disorders / Anemia				12. Sexual dysfunction			
13. Neurological disorders: MS / Parkinson's / Other				13. Vision problems			
14. Seizures / epilepsy				14. Ringing in ears/hearing probs.			
15. Tuberculosis/Hepatitis/HIV				15. Coordination / balance problems			
16. Currently/possibly pregnant				16. Difficulty walking			
17. Arthritis Rheumatoid arthritis Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	17. Swelling feet / ankles / legs Swelling hands / arms	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Lung problems Asthma Emphysema Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	18. Sleeping difficulty / apnea			
19. Ulcers / stomach problems				19. Shortness of breath / cough / difficulty swallowing			
20. Other: _____				20. Skin problems			
				21. Depression			
				22. Other: _____			

FAMILY HISTORY	Yes	No	Relative	SOCIAL HISTORY	Yes	No	Comments
Has anyone in your immediate family ever been treated for any of the following:				1. Do you exercise regularly?			
1. Diabetes				2. Do you smoke now?			
2. Heart Disease				3. Did you ever smoke?			
3. High blood pressure				4. If yes, how many cigarettes / cigars per day? _____			
4. Cancer				5. Do you drink alcohol?			
5. Stroke				6. If yes, how many drinks per day? _____			
6. Arthritis				7. How many caffeine beverages do you drink per day? _____			
7. Mental illness				8. Do you have allergies?			
8. Alcohol / drug dependency				9. Do you have Latex allergy?			
9. Kidney / liver disease				10. Occupation: _____			
10. Lung disease				11. Leisure activities: _____			

List any prescription medications you are currently taking (pills, injections, skin patches):

1. _____ 5. _____
 2. _____ 6. _____
 3. _____ 7. _____
 4. _____ 8. _____

List any surgeries or recent hospitalizations and include the approximate date:

1. _____
 2. _____
 3. _____
 4. _____

Do you take any of the following over the counter medications?			
	Yes	No	Comment
Aspirin			
Tylenol			
Advil / Motrin / Ibuprofen			
Laxatives			
Decongestants			
Antacids			
Antihistamines			
Vitamins			
Tagamet / Pepcid AC / Zantac			
Other: _____			

List any broken bones, sprains, dislocations and include the approximate date:

1. _____
 2. _____
 3. _____
 4. _____

Previous injuries (neck, back, shoulder, arm, leg, foot, head) for which you have received therapy and include approximate date:

1. _____
 2. _____
 3. _____

Previous history of falls. Yes No

Any injury(ies) as a result of a fall?
 List: _____

Do you use alternative medicines or herbal supplements?			
Are you allergic to any medications?			
Do you use recreational drugs?			

TESTS	Yes	No	Area of Body
1. X-ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Ultrasound / Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. EMG / NCV	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you been in a car accident or other accident? Yes No _____

Is there anything that would interfere with your participating in therapy? Yes No _____

Do you have a need to discuss any emotional or physical harm that you may be experiencing? Yes No _____

Do you ever feel unsafe at home or has anyone hit you or tried to injure you? Yes No _____

During the past month, have you been feeling down, depressed, or hopeless? Yes No _____

During the past month, have you been bothered by having little interest or pleasure in doing things? Yes No _____

Describe the problem(s) for which you seek rehab services? _____

What happened? _____

How did the problem begin? _____

When did the problem begin? _____

What makes the problem better? _____

What makes the problem worse? _____

When is your follow-up appointment with the doctor? _____