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
1. Heart Disease Heart attack Pacemaker	☐ ☐ ☐	☐ ☐ ☐	_____ _____ _____
2. High blood pressure			
3. Diabetes			
4. Cancer			
5. Kidney / bladder problems			
6. Liver problems			
7. Thyroid problems			
8. Prostate problems			
9. Stroke / TIA			
10. Circulation problems			
11. Osteoporosis			
12. Blood disorders / Anemia			
13. Neurological disorders: MS / Parkinson's / Other			
14. Seizures / epilepsy			
15. Tuberculosis/Hepatitis/HIV			
16. Currently/possibly pregnant			
17. Arthritis Rheumatoid arthritis Osteoarthritis	☐ ☐ ☐	☐ ☐ ☐	_____ _____ _____
18. Lung problems Asthma Emphysema Bronchitis	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	_____ _____ _____ _____
19. Ulcers / stomach problems			
20. Other:_____			

Current Health	Yes	No	Comments
1. Weakness in arms Weakness in legs Other	☐ ☐ ☐	☐ ☐ ☐	_____ _____ _____
2. Weight loss / gain			
3. Tiredness / fatigue			
4. Nausea / vomiting			
5. Fever / Chills / Sweats			
6. Dizziness/light-headed/headaches			
7. Numbness / tingling			
8. Bowel / urinary problems			
9. Joint / bone pain			
10. Night pain			
11. Chest pain / heart palpitations			
12. Sexual dysfunction			
13. Vision problems			
14. Ringing in ears/hearing probs.			
15. Coordination / balance problems			
16. Difficulty walking			
17. Swelling feet / ankles / legs Swelling hands / arms	☐ ☐	☐ ☐	
18. Sleeping difficulty / apnea			
19. Shortness of breath / cough / difficulty swallowing			
20. Skin problems			
21. Depression			
22. Other:_____			

FAMILY HISTORY	Yes	No	Relative
Has anyone in your immediate family ever been treated for any of the following:			
1. Diabetes			
2. Heart Disease			
3. High blood pressure			
4. Cancer			
5. Stroke			
6. Arthritis			
7. Mental illness			
8. Alcohol / drug dependency			
9. Kidney / liver disease			
10. Lung disease			

SOCIAL HISTORY	Yes	No	Comments
1. Do you exercise regularly?			
2. Do you smoke now?			
3. Did you ever smoke?			
4. If yes, how many cigarettes / cigars per day? _____			
5. Do you drink alcohol?			
6. If yes, how many drinks per day? _____			
7. How many caffeine beverages do you drink per day? _____			
8. Do you have allergies?			
9. Do you have Latex allergy?			
10. Occupation: _____			
11. Leisure activities:_____			

Please turn over and complete the other side

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

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:_____

TESTS	Yes	No	Area of Body
1. X-ray	☐	☐	_____
2. MRI	☐	☐	_____
3. Ultrasound / Bone Scan	☐	☐	_____
4. CT Scan	☐	☐	_____
5. EMG / NCV	☐	☐	_____
6. Other: _____	☐	☐	_____

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? _____