ADVANCE REHABILITATION
MEDICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE:** _____
REFERRING PHYSICIAN'S NAME: _____ **DATE OF INJURY OR ONSET:** _____
PRIMARY CARE PHYSICIAN'S NAME: _____ **ARE YOU PRESENTLY WORKING? Y ES NO**
CAUSE OF INJURY OR ONSET: _____ **DATE OF NEXT MD APPT:** _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? ◯YES ◯NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? ◯YES ◯NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) ◯YES ◯NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? ◯YES ◯NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) ◯EXCELLENT ◯GOOD ◯FAIR ◯POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ **WEAR GLASSES / CONTACTS?: YES NO**

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? ◯YES ◯ NO IF YES, WHEN_____
AND WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) ◯YES ◯ NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:

_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) ◯YES ◯NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: Medication _____**Reaction**_____ **Other** _____**Reaction**_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? Select On **If yes what is the Reaction**_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- □ ANEMIA
- □ ARTHRITIS
- □ CANCER
- □ CARDIOVASCULAR PROBLEMS
- □ HOLTER MONITOR - currently wearing?
  - □ PACEMAKER
  - □ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
- □ LOW BLOOD PRESSURE
- □ CURRENTLY PREGNANT
- □ DIABETES □controlled □uncontrolled
- □ DEPRESSION
- □ DIZZINESS/FAINTING
- □ FRACTURES
- □ HEADACHES
- □ HEPATITIS/HIV
- □ KIDNEY PROBLEMS
- □ MRSA (Methicillin Resistant Staphylococcus Aureus)
- □ OSTEOPOROSIS
- □ RESPIRATORY PROBLEMS
  - □ ASTHMA □ controlled □ uncontrolled
  - □ COPD □ controlled □ uncontrolled
  - □ Other
- □ SEIZURES □ controlled □ uncontrolled
- □ THYROID PROBLEMS
- □ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

☐ **ANY OTHER MEDICAL PROBLEMS:** _____

SIGNATURE OF PATIENT: _____ **REVIEWED BY Therapist:** _____**Date**_____

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