

Outpatient Health History (Confidential)

Primary Care Physician: _____ Ref Provider: _____

Reason for visit: _____

Person completing form: _____ Patient Other _____ Date: _____

PAST MEDICAL HISTORY (PLEASE CHECK ALL MEDICAL DIAGNOSIS AND CONDITIONS THAT APPLY)

- | | | |
|--|---|--|
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures Disorder | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> HIV/AIDs | <input type="checkbox"/> Atrial Filtration | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Other Cancer: _____ |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Trouble | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> MI/Heart Attack | |

* Many rehab clinic products contain Latex. Do you have any allergy to Latex? Yes No

PAST SURGICAL HISTORY:

- | | | |
|--|---|---|
| <input type="checkbox"/> No prior surgery | <input type="checkbox"/> Heart valve repair | <input type="checkbox"/> TAH (Hysterectomy) |
| <input type="checkbox"/> No history anesthesia reactions | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> TAH with BSO (Hysterectomy w/ ovaries) |
| <input type="checkbox"/> No history surgical complications | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Inguinal Hernia repair | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Vascular Bypass Graft |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bladder Suspension | <input type="checkbox"/> Liver transplant | |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Neck Surgery | |
| <input type="checkbox"/> CABG (Coronary Artery Bypass Graft) | <input type="checkbox"/> Rotator cuff Repair | |
| <input type="checkbox"/> Carotid Endarterectomy | | |
| <input type="checkbox"/> Carpal tunnel release | | |

FAMILY HISTORY:

- | | |
|---|---|
| <input type="checkbox"/> Anesthesia Problem | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Other |

SOCIAL HISTORY:

- | |
|---|
| <input type="checkbox"/> Single |
| <input type="checkbox"/> Married |
| <input type="checkbox"/> Domestic Partner |
| <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Separated |
| <input type="checkbox"/> Widowed |

WORK HISTORY:

- | |
|---|
| <input type="checkbox"/> Physical Work |
| <input type="checkbox"/> Sedentary Work |
| <input type="checkbox"/> Retired |
| <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Regular Duty |
| <input type="checkbox"/> Light Duty |
| <input type="checkbox"/> Out of Work |
| <input type="checkbox"/> Disabled |

SMOKING STATUS:

- | |
|---|
| <input type="checkbox"/> Current every day smoker |
| <input type="checkbox"/> Current some day smoker |
| <input type="checkbox"/> Former smoker |
| <input type="checkbox"/> Never smoker |

ALCOHOL DRINKS/DAY:

- | |
|-----------------------------------|
| <input type="checkbox"/> Never |
| <input type="checkbox"/> Rarely |
| <input type="checkbox"/> Moderate |
| <input type="checkbox"/> >2 |
| <input type="checkbox"/> >5 |

DRUG USE:

- | |
|--------------------------------------|
| <input type="checkbox"/> Never |
| <input type="checkbox"/> Former |
| <input type="checkbox"/> Current |
| <input type="checkbox"/> IV drug use |
| <input type="checkbox"/> Other |

DO YOU CURRENTLY HAVE ANY OF THE FOLLOING SYMPTOMS? (ROS-CS)

	YES	NO		YES	NO
Cough productive sputum	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence of urine	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence of stool	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Frequent falls	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Infrequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Changes in color of skin	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Visual changes	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Confusion/altered mental status	<input type="checkbox"/>	<input type="checkbox"/>
Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with concentration	<input type="checkbox"/>	<input type="checkbox"/>

NUTRITION:

1. Are you concerned about your nutrition? Yes No
2. Have you had an unexplained weight loss? Yes No
3. Have you had an unexplained weight gain? Yes No Specify loss or gain: _____
4. Current weight: _____
5. Current height: _____

FALLS:

1. Have you fallen in the last 30 Days? Yes No When: _____
2. Has any falls resulted in injury? Yes No Specify: _____



PHARMACY

1. Name of Pharmacy:

2. Address of Pharmacy:

3. Phone number of Pharmacy?

4. Mail Order? Yes No

ALLERGIES/ DRUG INTERACTIONS

Please list:

CURRENT MEDICATIONS (INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBAL PREPARATIONS)

Medication Name	Dose	Frequency	Reason

PAIN:

Do you currently have pain or have you had pain in the recent past?

Yes, if yes complete pain questionnaire below

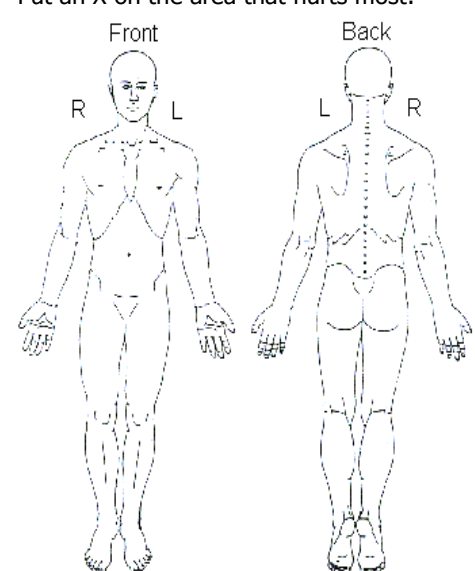
No, if no proceed to page 4

Does your pain have any of the following characteristics?

- | | | | |
|-------------|--------------------------|----------------|--------------------------|
| Dull | <input type="checkbox"/> | Nagging | <input type="checkbox"/> |
| Aching | <input type="checkbox"/> | Numbing | <input type="checkbox"/> |
| Throbbing | <input type="checkbox"/> | Pins & needles | <input type="checkbox"/> |
| Shooting | <input type="checkbox"/> | Tingling | <input type="checkbox"/> |
| Stabbing | <input type="checkbox"/> | Knife like | <input type="checkbox"/> |
| Gnawing | <input type="checkbox"/> | pressure | <input type="checkbox"/> |
| Sharp | <input type="checkbox"/> | Unbearable | <input type="checkbox"/> |
| Tenderness | <input type="checkbox"/> | Popping | <input type="checkbox"/> |
| Exhausting | <input type="checkbox"/> | Clicking | <input type="checkbox"/> |
| Tiring | <input type="checkbox"/> | Locking | <input type="checkbox"/> |
| Penetrating | <input type="checkbox"/> | Grinding | <input type="checkbox"/> |

On the diagram below, shade in the **body part** where you feel pain.

Put an X on the area that hurts most:



- Please rate your pain by circling the number that describes your pain at **its worst in the last three (3) days:**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain
- Please rate your pain circling the number that describes your pain at **its least in the last three (3) days:**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain
- Please rate your pain by circling the number that tells how much **pain you have right now:**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

EXACERBATION: PLACE A (✓) BESIDE WHAT MAKES YOUR PAIN WORSE

Nothing	Bending	Certain movement	Walking up stairs	Heat
Activity	Bending forward	Change in positions	Walking down stairs	Stretching
Sitting	Bending backwards	Reaching up	Lying down	Weather changes
Standing	Twisting	End of day	Lying on side	Rainy weather
Walking	Turning	Morning activities	Squatting	Cold weather
Lifting	Driving	Evening activities	Kneeling	Hot weather
Carrying	Sneezing	Sitting up for long	Ice	Yoga

RELIEF: PLACE A (✓) BESIDE WHAT RELIEVES YOUR PAIN

Nothing	Standing	Driving	Walking down stairs	Heat
Rest	Walking	Certain movement	Lying down	Stretching
Medications	Bending	Change in positions	Sleeping	Weather changes
Activity	Bending forward	Morning activities	Lying on side	Rainy weather
Exercise	Bending backwards	Evening activities	Squatting	Cold weather
Massage	Twisting	Sitting for long periods	Kneeling	Hot weather
Sitting	Turning	Walking up stairs	Ice	Yoga

WHAT PRIOR TREATMENT HAVE YOU TRIED FOR YOUR PAIN? PLACE A (✓)

No treatment	Physiatrist
Medications	Orthopedist
Physical therapy	Pain management
Occupational therapy	Opioid pain management
Emergency department	Neurosurgeon
Occupational health	Chiropractor
Primary care physician	