Hammond-Henry HOSPITAL

Hammond-Henry Hospital
Rehabilitation Services
Past Medical History Form

Patient Name: _____ Date: _____

Are you presently working: ❑ Yes ❑ No Cell Phone #: (_____)_____

Are you off work due to this injury? ❑ Yes ❑ No Occupation: _____

Date of next physician's visit: ___/___/___ Workman's Comp Injury? ❑ Yes ❑ No

Date of injury / onset: ___/___/___ Have you ever had these symptoms before? ❑ Yes ❑ No

Check any of the following diagnostic test you have had for this condition.

❑ X-ray ❑ MRI ❑ CT Scan ❑ other: _____

Have you had a related surgery? ❑ Yes ❑ No Have you been hospitalized in the last 60 days? ❑ Yes ❑ No

Do you have, or have you had any of the following? **Check (✓) all that apply**.

❑ (A) Congestive Heart Failure
❑ (A) Diabetes/ Diabetic Neuropathy
❑ (A) Chest Pain / Angina
❑ (A) High Blood Pressure
❑ (A) Low Blood Pressure
❑ (A) Heart Disease
❑ (A) Heart Attack
❑ (A) Heart Palpitations
❑ (A) Pacemaker
❑ (A) Urinary Tract Infection
❑ (A) Respiratory Issues
❑ (A) Smoking
❑ (A) Ringing in your Ears/Perforated Eardrum
❑ (A) Seizures (last incident _____)
❑ (A) Dizziness / Fainting
❑ (A) Absence of Cough Reflex/Aspiration Risk
❑ (A) Poor tolerance Cold/Heat/Skin Sensitivity
❑ (A) Multiple Sclerosis
❑ (A) Renal/Kidney Problems
❑ (A) Any known infections

❑ Allergies
❑ Hernia
❑ Cancer/Chemo/Radiation (when_____)
❑ Metal Implants
❑ Arthritis
❑ Recent Fractures
❑ Headaches/Migraines
❑ Circulatory Problems
❑ Surgeries (please list)

_____
_____
_____

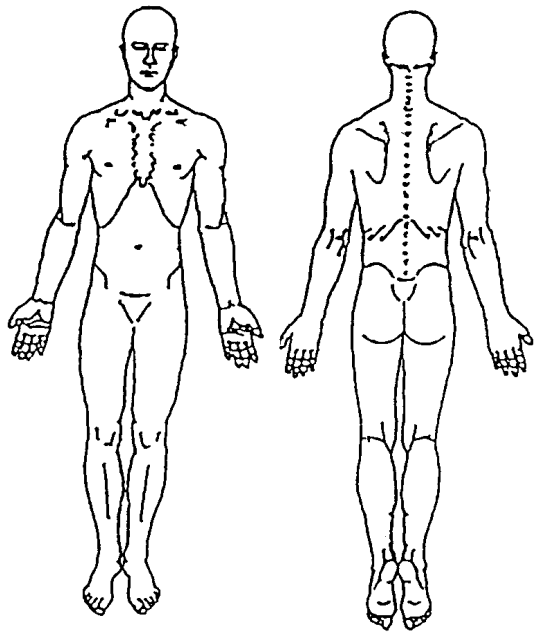
❑ Special Diet Guidelines
❑ Hypoglycemia
❑ Liver/Gallbladder Problems
❑ Stroke_____
❑ If applicable, are you pregnant? ❑ Yes ❑ No

(A) Are you experiencing episodes of bladder/bowel/ diarrhea incontinence? ❑ Yes ❑ No (last incident)_____

(A) Skin Abnormalities/Open Wounds ❑ Yes ❑ No (location _____)

Are you currently receiving Home Health Services? ❑ Yes ❑ No

Please explain checked boxes	***Please list what medications you are taking and for what condition.***



Please use the figure on left to tell us where your pain is located.

KEY:

Numbness ========

Pins & Needles *ooooooo*

Burning Pain *xxxxxxxx*

Stabbing Pain **/ / / / / / /**

Pain Assessment

On a scale of 0-10 *(0=no pain, 10=severely disabling pain requiring hospitalization)*

Please circle your pain level at rest 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Please circle your pain level with activity 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10

Please **check (✓)** any activities below that causes you pain or restrict your performance/function.

- ❑ Sleeping
- ❑ Sitting
- ❑ Cooking/eating
- ❑ Care for pet(s)
- ❑ Walking
- ❑ Running
- ❑ Sports (please list)_____
- ❑ Work (please list jobs)_____
- ❑ Hobbies (please list)_____
- ❑ Bathing
- ❑ Getting up from bed/chairs/toilet
- ❑ Lifting and carrying
- ❑ Laundry
- ❑ Making your bed
- ❑ Driving
- ❑ Pushing/pulling
- ❑ Lawn care
- ❑ Stairs
- ❑ Shopping
- ❑ Continence
- ❑ Cleaning/home chores
- ❑ Falls/maintaining balance
- ❑ Other (please explain) _____
  _____

Please list three (3) activities you have difficulty performing due to current condition.

1. _____
2. _____
3. _____

_____ Signature

_____ Relationship to Patient (if a minor)

____/____/____ Date

In the rare instance of an emergency, whom should we contact?

_____ Name

(_____) _____ Phone Number

REH HX