Onslow Memorial Hospital
REHABILITATION

PATIENT MEDICAL HISTORY AND SUMMARY LOG

Please print out, fill-in and bring to your evaluation along with your list of medications

Home Health: Do you currently have a *therapist* or *nurse* that comes to your home? □ No □ Yes **(if yes, please call 910-577-2372)**

Physician Who Ordered Therapy: _____

Living Situation: □ live alone □ with spouse □ family member(s) Do you have stairs? □ yes □ no ____#

WORK STATUS: Occupation: _____ Employer: _____
Type of shift: □ Full-time □ Part-time □ Light Duty □ Out of work due to injury/condition □ Retired

IF MINOR: Name of School: _____

GENERAL HEALTH STATUS: (please check all that apply)

Dominant Hand: □ right □ left Vision: □ good □ need glasses Hearing: □ good □ hearing aid Known Allergies? : □ Yes □No (list): _____ _____ Are you pregnant? □ yes □ no Precautions:_____	□ arthritis / joint pain □ asthma / breathing problems □ cancer _____(type) □ depression □ diabetes □ osteoporosis □ heart condition □ high blood pressure □ high cholesterol □ history of past stroke	□ metal implants □ pacemaker □ recent weight gain / loss □ reflux / heart burn □ seizures □ swallowing problems □ urinary incontinence □ drug / alcohol dependent □ use tobacco products * years of smoking: _____ □ other:_____

Past surgeries or conditions: _____

CURRENT CONDITION: How did this condition begin? _____

Date condition began: _____ Hospitalized? □ yes □ no; for how long?_____ where?_____

Have you had therapy for it before now? □ yes □ no; for how long?_____ what type? PT OT ST OTHER _____

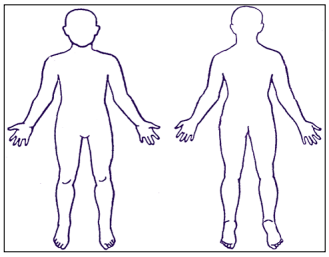
Have you had surgery or any other treatment for this condition? If yes, describe:_____

What tests, including x-rays, have been done for this condition?_____

Are you having pain? □ yes □ no; describe location, frequency and type of pain below:

_____

Mark the area of your body affected



If in pain, please rate:

0	1	2	3	4	5
No Pain	Mild	Moderate		Severe	Excruciating

What helps your pain?_____ What makes your pain worse?_____

List all current medications, herbal supplements and over-the-counter meds: _____

_____

_____
Patient or Guardian Signature / Date