MedStar National
Rehabilitation Network

Outpatient Health History (Confidential)

Primary Care Physician: _____ **Ref Provider:** _____
Reason for visit: _____
Person completing form: _____ ☐ **Patient** ☐ **Other**_____ **Date:** _____

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

- ☐ Bleeding Problems
- ☐ Diabetes
- ☐ Hepatitis
- ☐ HIV/AIDs
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Rheumatoid Arthritis
- ☐ Seizures Disorder
- ☐ Thyroid Disorder
- ☐ Atrial Filtration
- ☐ CVA/Stroke
- ☐ Hypertension
- ☐ Heart Trouble
- ☐ MI/Heart Attack
- ☐ Pace Maker
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Other Cancer: _____
- ☐ Other

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

PAST SURGICAL HISTORY:

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

FAMILY HISTORY:

- ☐ Anesthesia Problem
- ☐ Alcoholism
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Disease
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Other

SOCIAL HISTORY:

- ☐ Single
- ☐ Married
- ☐ Domestic Partner
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

WORK HISTORY:

- ☐ Physical Work
- ☐ Sedentary Work
- ☐ Retired
- ☐ Homemaker
- ☐ Regular Duty
- ☐ Light Duty
- ☐ Out of Work
- ☐ Disabled

SMOKING STATUS:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

ALCOHOL DRINKS/DAY:

- ☐ Never
- ☐ Rarely
- ☐ Moderate
- ☐ >2
- ☐ >5

DRUG USE:

- ☐ Never
- ☐ Former
- ☐ Current
- ☐ IV drug use
- ☐ Other

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

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

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:_____

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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**

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PAIN:

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

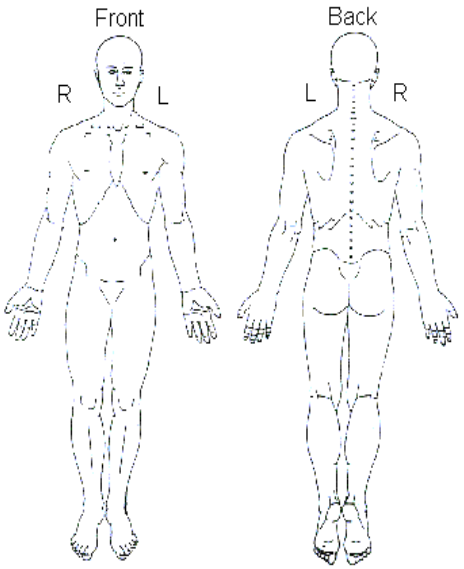
- ☐ **Yes**, if yes complete pain questionnaire below
- ☐ **No,** if no proceed to page 4

Does your pain have any of the following characteristics?

Dull	☐	Nagging	☐
Aching	☐	Numbing	☐
Throbbing	☐	Pins & needles	☐
Shooting	☐	Tingling	☐
Stabbing	☐	Knife like	☐
Gnawing	☐	pressure	☐
Sharp	☐	Unbearable	☐
Tenderness	☐	Popping	☐
Exhausting	☐	Clicking	☐
Tiring	☐	Locking	☐
Penetrating	☐	Grinding	☐

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

Put an X on the area that hurts most:



1. 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

2. 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

3. 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

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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	Opiod pain management
Emergency department	Neurosurgeon
Occupational health	Chiropractor
Primary care physician	