Beebe Healthcare Physical Rehabilitation Services
Medical History Page 1

Patient Identification Label

Do you have, or have you had any of the following medical conditions? (Please check Yes or No) ☐**see attached**

Yes	No		Yes	No		Yes	No	
☐	☐	**Heart Disease**	☐	☐	**High Blood Pressure**	☐	☐	**Stroke/CVA/TIA**
☐	☐	**Heart Attack**	☐	☐	**Dizziness/ Fainting**	☐	☐	**Seizures**
☐	☐	**Pacemaker**	☐	☐	**Headaches**	☐	☐	**Osteoporosis/Osteopenia**
☐	☐	**Heart Palpitations**	☐	☐	**Hepatitis**	☐	☐	**Recent Fractures**
☐	☐	**Heart Failure**	☐	☐	**Cancer**	☐	☐	**Dementia**
☐	☐	**Chest Pain/Angina**	☐	☐	**Hernia**	☐	☐	**Diabetes**
☐	☐	**Asthma/Breathing Problems**	☐	☐	**Bowel/Bladder Problems**	☐	☐	**Arthritis**
☐	☐	**Kidney Disease**	☐	☐	**Neurological Disease**	☐	☐	**Other:**__________

If you answered yes to any of the above, please explain below, and give an approximate date: ☐see attached

____

____

____

Do you have a latex allergy? ☐ No ☐ Yes Reaction if Yes- ____________________

Are you allergic to any medications? If so, please list & describe reaction: ☐see attached

____

____

Please list any medications you are currently taking and for what condition: ☐see attached (Include over the counter and prescription)

____

____

____

____

Please list any surgical history: (Type of surgery and date) ☐see attached ____________________

____

____

____

Have you had any non-surgical hospital admissions in the past year? (Please give reason and date) ☐see attached

____

____

____

Please turn over and fill out page 2

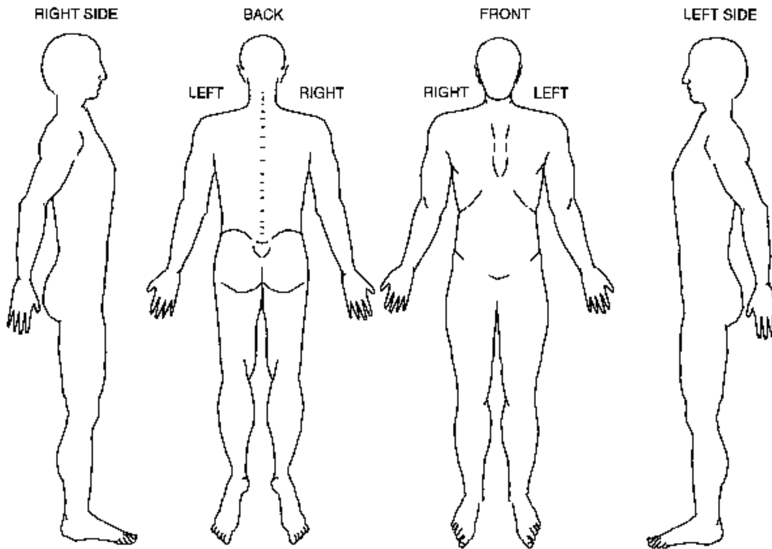
Patient Signature or
Authorized Representative: ____________________ **Date:** __________ **Time:** ________

Therapist Signature: ____________________ **Date:** __________ **Time:** ________

Beebe Healthcare Physical Rehabilitation Services
Medical History Page 2

Patient Identification Label

Body Chart for Pain:
If pain is one of the reasons why you are here, please mark the location and type of pain you are experiencing using the diagram below.



Key
xxxx– aching pain
oooo – sharp pain
==== - burning pain
//// - numbness/tingling
**** - tightness/discomfort

Fall Risk Assessment: For your safety, we would like to know if you are at risk for a fall.

1. Have you had 2 or more falls in the past year? □ Yes □ No **If yes, number of Falls:** ___________
2. Have you had any fall in the past year with injury? □ Yes □ No **If yes, injuries sustained:** ___________
3. Are you afraid of falling? □ Yes □ No **If yes, please have patient fill out ABC questionnaire**
4. Do you have vision problems? □ Yes □ No **If yes, when was your vision last checked?** ___________
5. Do you have hearing loss? □ Yes □ No **If yes, when was your hearing last checked?** ___________

Please check any of the following that apply to you:

□ difficulties with walking □ use of an assistive device □ leg weakness □ age > 80 years old
□ urinary incontinence □ foot problems causing pain or difficulty walking □ peripheral neuropathy
□ take 4 or more medications (prescribed and over-the-counter) □ throw rugs, poor lighting, or other hazards in your home

Speech Language Screening: Please answer these questions regarding your speech and swallowing.

1. Do you experience coughing, choking, change of breathing, and/or sensation of food stuck in your throat/mouth when consuming food/liquids during most meals? □ Yes □ No
2. Do you have a difficult time thinking of words, expressing yourself, being understood by others, following directions, speaking clearly, and/or speaking loudly in conversation? □ Yes □ No
3. Do you have difficulty remembering names/appointments/events, paying attention, and/or solving problems that impact how you safely perform daily activities? □ Yes □ No

Please tell us how you would like to be addressed while under our care. **Name:** ___________

Patient Signature or Authorized Representative: ___________ **Date:** ___________ **Time:** ___________

Therapist Signature: ___________ **Date:** ___________ **Time:** ___________