

Label Here

Outpatient Medical History/Screening Form

To be completed by the patient

Patient Name: _____ Spoken Language: _____
 Emergency Contact: _____ Telephone #: _____
 Family Physician/Internist: _____ Telephone #: _____
 Religious/Cultural Needs: NO YES Please Explain: _____
 Special Learning Needs: NO YES Please Explain: _____

Why are you here? _____

Medical Information:					
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimers	<input type="checkbox"/>	<input type="checkbox"/>
Hypotension	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain /Angina /Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema /Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Urgency / Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding / Bruising (recent history)	<input type="checkbox"/>	<input type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
History of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Have you had/have a Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>
Cancer / Tumors / Growths	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Active seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	History of pressure sores	<input type="checkbox"/>	<input type="checkbox"/>
Swelling Of Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Are you in pain?	<input type="checkbox"/>	<input type="checkbox"/>
DATE: _____ AREA: _____	<input type="checkbox"/>	<input type="checkbox"/>	Location of pain _____		
DATE: _____ AREA: _____	<input type="checkbox"/>	<input type="checkbox"/>			
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	If you answered yes to any of the above:		
Light-Headedness / Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Are you under the care of an	YES	NO
Anxiety / Panic Attacks (recent)	<input type="checkbox"/>	<input type="checkbox"/>	MD for these conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Depression(recent)	<input type="checkbox"/>	<input type="checkbox"/>			

Allergies: _____

Surgery(s) within last 3 months - Include Dates: _____
What are your treatment goals?: _____

If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant. Advanced Directives are not honored in the Outpatient Setting.

FALL RISK ASSESSMENT*:	YES	NO	NUTRITIONAL SCREENING	YES	NO
Have you fallen within the last year?	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss? (>5% in last 30 days)	<input type="checkbox"/>	<input type="checkbox"/>
If so, how many times? _____			Recent loss of appetite/aversion to food?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of these falls resulted in an injury within the last year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you afraid of falling?	<input type="checkbox"/>	<input type="checkbox"/>	Decrease in food intake?(<50% for 3 days or more)	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently felt unsteady on your feet or in your wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	Are you under the care of a MD for these conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience dizziness or vertigo?	<input type="checkbox"/>	<input type="checkbox"/>	CURRENT MEDICATION: (List below)		
Do you have vision problems that are not corrected by glasses?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you use sedatives that affect your level of alertness during the day?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have memory / cognitive difficulties?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have a lower extremity disability that affects walking?	<input type="checkbox"/>	<input type="checkbox"/>			
AS PER CMS FALL SCREENING CRITERIA					
*Patient is considered a fall risk if patient has fallen two or more times in the past year					
*Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year					
			Are all meds prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No	

***FALL RISK-** Patient is considered a fall risk if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should refer to the Fall Prevention Policy in the OP KRC P&P manual.

PATIENT SIGNATURE: _____ **DATE:** _____

Relationship if other than patient / parent / guardian if minor: _____

**This information will be used as a guide to your treatment plan.
If you need any medical follow-up, please contact your physician**

To be completed by evaluating Therapist	
Patient has been identified as a fall risk :	yes no
If yes, fall prevention program has been implemented:	yes no
Patient has been identified as a nutrition risk :	yes no (If yes, notify MD)
Patient would benefit from a Social Services referral:	yes no (yes if therapist feels patient life is threatened, or if patient is a threat to others)

Therapist Signature: _____ **Date:** _____

(Therapist has reviewed medical history form with patient)