Penn Ohio Rehabilitation
PHYSICAL • OCCUPATIONAL • AQUATIC

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NAME:_____ DATE:_____

Health History:

Please indicate if you have ever been diagnosed with, treated for, and/or experienced symptoms of any of the following:

- ☐ Kidney Disease
- ☐ Angina/Chest Pain
- ☐ Heart Attack/Heart Disease
- ☐ High/Low Blood Pressure
- ☐ Diabetes
- ☐ Shortness of Breath
- ☐ Asthma/Emphysema
- ☐ Dizziness/Syncope
- ☐ Seizures
- ☐ Bowel Problem (Constipation/Diarreha)
- ☐ Bladder Problems
- ☐ Rectal/Vaginal Bleeding
- ☐ Osteoporosis
- ☐ Stroke/TIA
- ☐ Rheumatic Fever
- ☐ Tuberculosis/TB
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Circulation Problems
- ☐ Phlebitis
- ☐ Muscle Disorder
- ☐ Nerve Disorder
- ☐ Tobacco Use
- ☐ Alcohol Use
- ☐ Unexplained cough of 2 wks or more
- ☐ Unexplained weight gain/loss
- ☐ Loss of appetite
- ☐ Night sweats
- ☐ Unexplained fever
- ☐ Bloody sputum
- ☐ Depression/Anxiety
- ☐ Cancer _____

Number of falls in Past Year? _____
Did you suffer any injuries from the fall/falls?: ____ YES ____NO
Describe:_____

Accidents: ☐
Auto_____
Workers Comp_____
Other:_____

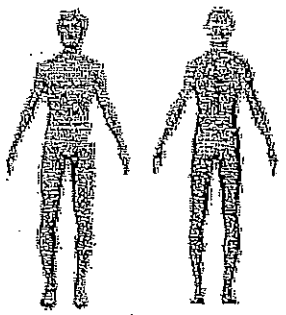
Surgical History:_____

☐

Please list the medications that you currently are taking and the dosage:

Name of medication and dosage:		*Name of medication and dosage:*

Symptoms began on:_____ (mm/dd/yyyy)
Briefly describe your symptoms:_____
How did your symptoms start:_____
Average pain intensity: (indicate where you have your pain &other symptoms on the diagram)



Last 24 hours:

No Pain	1	2	3	4	5	6	7	8	9	10	Worse Pain

Past Week:

No Pain	1	2	3	4	5	6	7	8	9	10	Worse Pain

How often do you experience your symptoms?

Constantly &76-100%)	Frequently (51-75%)	Occasionally (26-50%)	Intermittently (0-25%)

How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

Not at all	A little bit	Moderately	Quite a bit	Extremely

How is your condition changing, since care began at THIS facility?

N/A – 1st visit	Much worse	Worse	A little worse	No change	A little bit better	Better	Much Better

In general, would you say your overall health right now is:

Excellent	Very good	Good	Fair	Poor

Patient Signature:_____ Date:_____