Colleyville Physical Therapy & Sports Rehab

Date:__________________

OT PATIENT HEALTH HISTORY

Patient Name: ________________________________DOB: ____________ Primary Care Physician:____________________________

Gender: M F **Age:** ____ **Smoker/Tobacco User:** Y N **Pregnant:** Y N

Do you have a pacemaker? Y N **Are you latex sensitive?** Y N

Occupation: ____

Describe your regular workout routine: ____

Medication allergies you may have:____

Have you ever taken steroid medications for any medical conditions? Y N

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Y N

PAST MEDICAL HISTORY:

Past surgical history (list all and date): ____

Have you RECENTLY noticed any of the following (check all that apply)?

- ☐ Fatigue
- ☐ Numbness or tingling
- ☐ Constipation
- ☐ Fever/chills/sweats
- ☐ Muscle weakness
- ☐ Diarrhea
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Shortness of breath
- ☐ Weight loss/gain
- ☐ Heartburn/indigestion
- ☐ Fainting
- ☐ Difficulty with balance
- ☐ Difficulty swallowing
- ☐ Cough
- ☐ Falls
- ☐ Changes in bowel or bladder function
- ☐ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Depression
- ☐ Thyroid problems
- ☐ Heart Problems
- ☐ Lung problems
- ☐ Diabetes
- ☐ Chest pain/angina
- ☐ Tuberculosis
- ☐ Osteoporosis
- ☐ Bladder/Urinary tract infection
- ☐ High blood pressure
- ☐ Asthma
- ☐ Multiple Sclerosis
- ☐ Circulation problems
- ☐ Rheumatoid arthritis
- ☐ Epilepsy
- ☐ Blood clots
- ☐ Other arthritic conditions
- ☐ Eye problem/infection
- ☐ Stroke
- ☐ Ulcers
- ☐ Anemia
- ☐ Kidney problem/infection
- ☐ Liver problems
- ☐ Bone or joint infection
- ☐ Sexually transmitted disease/HIV
- ☐ Hepatitis
- ☐ Chemical dependency (alcoholism)
- ☐ Pelvic inflammatory disease
- ☐ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart Problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ High blood pressure
- ☐ Depression
- ☐ Blood clots

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

What activities are most limited: ____

Do you have any barriers to learning or participating in occupational therapy? If so, please list:

____

Fall Risk: Have you had any falls in the past year YES NO How Many?__________ Do you have a fear of falling **YES** **NO**

For Therapist Use Only

Any signs of elder maltreatment? **YES** **NO**

Reviewed with patient on ___________ ____

Date Signature

Therapist Initials: _______________