Patient Name
Date of Birth

Einstein Healthcare Network - MossRehab
Medical History / Patient Problem List

MEDICAL PROBLEMS: *(please check only those that apply)*

CARDIOVASCULAR
☐ **No Identified Problem**
☐ Hypertension (High BP)
☐ Hypotension (Low BP)
☐ Heart Attack
☐ Chest Pain / Angina
☐ Irregular Rhythm or Murmur
☐ Congestive Heart Failure
☐ Varicose Veins
☐ Pacemaker / ☐ Defibrillator
☐ Circulation Problems
☐ Pain in Calves with walking
☐ Blood Clots / Phelbitis
☐ Aneurysm
☐ Blood / Bleeding Disorder
☐ Other_____

METABOLIC
☐ **No Identified Problem**
☐ Diabetes
  ☐ Insulin Dependent
  ☐ Oral Medications
  ☐ Diet Controlled
☐ Blood Sugar ☐ High ☐ Low
☐ Hyperthyroid
☐ Hypothyroid
☐ Other_____

SOCIAL / PSYCHOLOGICAL
☐ **No Identified Problem**
☐ Alcohol Use ____ Times a Week
☐ Tobacco Use ____ Packs a Day
☐ Substance Abuse
☐ Depression
☐ Anxiety / ☐ Panic
☐ Claustrophobia
☐ ADD / ☐ ADHD
☐ History Abuse
☐ Under care of a Psychiatrist
☐ Under care of a Psychologist
☐ Other_____

ORTHOPEDIC
☐ **No Identified Problem**
☐ Joint Replacements
Type: _____
Type: _____
☐ Metal Implants / Internal Plate & Pins
☐ Osteoporosis ☐ Osteopenia
☐ Amputation
☐ Fractures / Broken Bones
☐ Spinal Problems
☐ Osteoarthritis
☐ Sprain / ☐ Strain
☐ Other_____

PULMONARY
☐ **No Identified Problem**
☐ Asthma / ☐ Bronchitis
☐ Emphysema / ☐COPD
☐ Asbestosis / Mesothelioma
☐ Shortness of Breath
☐ Tuberculosis (TB) / ☐ Exposure
☐ Pneumonia
☐ Snoring / ☐Sleep Apnea
☐ Breathing Devices
☐ Dysphagia (Swallowing Problems)
☐ Other_____

GASTROINTESTINAL
☐ **No Identified Problem**
☐ Hepatitis ☐ A ☐ B ☐ C
☐ Gastrointestinal Ulcers
☐ Hiatal Hernia ☐ Reflux
☐ Unexplained Weight Loss / Gain
☐ Anorexia ☐ Bulimia
☐ Gall Bladder Disease
☐ Nausea ☐ Vomiting
☐ Crohn's Disease ☐ Colitis
☐ Irritable Bowel Syndrome
☐ Diverticulitis
☐ Bowel Incontinence ☐ Leakage
☐ Constipation
☐ Other_____

NEUROLOGIC
☐ **No Identified Problem**
☐ Migraine
☐ Loss of Consciousness
☐ Balance Problems / Vertigo
☐ Fainting / Blackouts
☐ Parkinson's Disease
☐ ALS (Lou Gehrig's Disease)
☐ Rheumatic Fever
☐ Weakness in Arms or Legs
☐ Polio / Post-Polio Syndrome
☐ Epilepsy / Seizures
☐ Stroke (CVA) ☐ TIA
☐ Head Injury ☐ Concussion
☐ Memory Loss
☐ Confusion
☐ Spinal Cord Injury
Level: _____
☐ Multiple Sclerosis (MS)
☐ Coordination Problems
☐ Dizziness
☐ Aphasia / ☐ Speech Problems
☐ Shunt Placement
☐ Hypoxia
☐ Other_____

GENITOURINARY
☐ No Identified Problem
☐ Kidney Stones
☐ GYN Disorder
☐ Blood in Urine
☐ Kidney Disease / Failure
☐ Dialysis
Urinary ☐ Burning ☐ Urgency ☐ Freq
☐ Bladder Incontinence ☐ Leakage
☐ Prostate Disorder
☐ Other_____

GENERAL MEDICAL
☐ **No Identified Problem**
☐ Glaucoma / ☐Cataracts
☐ Vision Problems
☐ Glasses _____
☐ Hearing Deficit / ☐ Hearing Aide(s)
☐ Blood Disease ☐ Anemia
☐ Cancer
Type:_____
Location: _____
☐ Chronic Pain ☐ Night Pain
☐ Skin Problems
☐ Edema / Swelling
☐ Lymphedema
☐ Rheumatoid Arthritis
☐ Infectious Disease
☐ Zoster / Shingles ☐ Chicken Pox
☐ Sexually Transmitted Disease
☐ Other_____

PEDIATRIC / CHILDHOOD HEALTH HISTORY
Pediatric Patients ONLY

☐ **No Identified Problem**
☐ Intellectual Disability
☐ Down's Syndrome
☐ Developmental Concerns
☐ Autism Spectrum
☐ Behavior Concerns
☐ Cerebral Palsy
☐ Birth Complications
☐ Chromosomal Abnormalities
☐ Other_____

IMMUNIZATIONS
(List Actual Dates)
☐ DPT:
☐ Polio:
☐ MMR:
☐ TB:
☐ Chicken Pox:
☐ Hepatitis:
☐ HiB *(Bacterial Meningitis)*

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CURRENT & RELEVANT Medical Problems / Conditions / Injuries **NOT** Listed Above ☐ Not Applicable

CURRENT / PAST SURGICAL HISTORY *(Include Month / Year)* ☐ Not Applicable

CURRENT / PAST HOSPITALIZATIONS *(Include Month / Year)* ☐ Not Applicable

ALLERGIES

☐ Seasonal ☐ Latex ☐ Tape / Adhesives ☐ Perfume ☐ Cold Intolerance
☐ Other

WHAT IS THE REASON FOR YOUR THERAPY VISITS?
(List issues you experience with daily activities, mobility or communication)

Date of Onset *(Include Month / Year)* Date of Surgery *(Include Month / Year)*

WHAT ARE YOUR REHAB GOALS?

FOR PEDIATRIC PATIENTS, **What REHAB GOALS do you have for your CHILD**?

Are you currently receiving or have you received any of the following services within the past year?
☐ Physical Therapy ☐ Occupational Therapy ☐Speech / Swallowing Therapy ☐ Home Care
Current Height: ____' ____" Current Weight: _____Pounds Dietary Restrictions ☐ Yes ☐ No
Have you fallen in the last 6 months ☐ Yes ☐ No How Many Falls? _____
Are you Pregnant? ☐ Yes ☐ No *Due Date:*
Are there any religious or cultural practices that need to be considered in your care? ☐ Yes ☐ No Explain:

DIAGNOSTIC TESTS / IMAGING completed in this past year *(Include Body part & Month /Year)* ☐ Not Applicable
☐ XRay ☐ CT Scan
☐ MRI ☐ Other
☐ Other

List ALL CURRENT MEDICATIONS *(Prescription & Non-prescription)* ☐ See Provided List ☐ Not Applicable

Medication	Condition	Amount (Dosage)	How Often (Frequency)

List ALL CURRENT SUPPLEMENTS (*Nutritional Supplements, Vitamins, Herbal Remedies & Biomedical Treatments*) ☐ Not Applicable

Supplement	Condition	Amount (Dosage)	How Often (Frequency)

☐ Patient ☐ Parent or ☐ Legal Guardian Signature _____ Date_____

Therapist Signature _____ Date_____