Mount Auburn Hospital ~ Rehabilitation Services

Patient Medical Questionnaire

Patient Name: _____ **Unit #:** _____ **Date:** _____

Reason for Rehab Referral: _____

Date of Injury: _____ **Date of Surgery:** _____

Diagnostic Tests for current problem:

___ X-ray	___ Bone Scan	___ Myelogram
___ CT scan	___ EMG	___ M.R.I.
___ Blood Tests	___ Arthrogram	___ Other: _____

List any other treatment you have had for this problem: _____

_____

List Medications and what used for:

Med	Condition

List any Allergies: _____

Please check off any other medical problems you have:

Cardiovascular/Heart *(Check if Yes)*

❑ High blood pressure	❑ Heart attack	❑ Pacemaker	❑ Stroke
❑ Chest pain/Angina	❑ Palpitations	❑ Circulation problems	

Musculoskeletal *(Check if Yes)*

❑ Arthritis	❑ Fracture (recent/related to current problem)
❑ Osteoporosis	❑ Other bone or joint condition

Respiratory *(Check if Yes)*

❑ COPD	❑ Smoker
❑ Asthma	❑ Other lung disease (TB etc.) _____

Balance/Falls *(Check if Yes)*

❑ Fall(s) in the last 12 months	❑ Dizziness	❑ Vision problems
❑ Fainting episodes	❑ Vertigo/inner ear problems	❑ Bladder/bowel incontinence

Other (check which currently apply to you):

❑ Anxiety	❑ Headache/migraine	❑ Pregnancy
❑ Bipolar disorder	❑ Head injury	❑ Seizures/Epilepsy
❑ Blood disorder	❑ Hearing loss	❑ Skin condition
❑ Bladder/bowel problems	❑ HIV/Aids	❑ Stomach/GI
❑ Cancer	❑ Infectious disease	❑ Thyroid disease
❑ Depression	❑ Limitations on your activity level per MD	❑ Unexplained weight loss
❑ Diabetes		❑ Splint/brace
❑ Dialysis	❑ Major trauma	❑ Other _____
❑ Endometriosis	❑ Open wound	_____
❑ Fevers	❑ Past Surgeries	_____

Comments: _____

Completed by: _____ _____

Patient Name Date