Stony Brook
Southampton Hospital
240 Meeting House Lane, Southampton, NY 11968 Tel: 631-726-8520, Fax: 631-726-8291

Department of Rehabilitation

Name: _____ **Age:** _____ **Occupation:** _____ **Date:** _____

Marital Status: S/M/D/W Residence: One/Two story? Number of steps to enter home: _____
Do you use an assistive device? Cane/ Walker /Crutches/Other_____

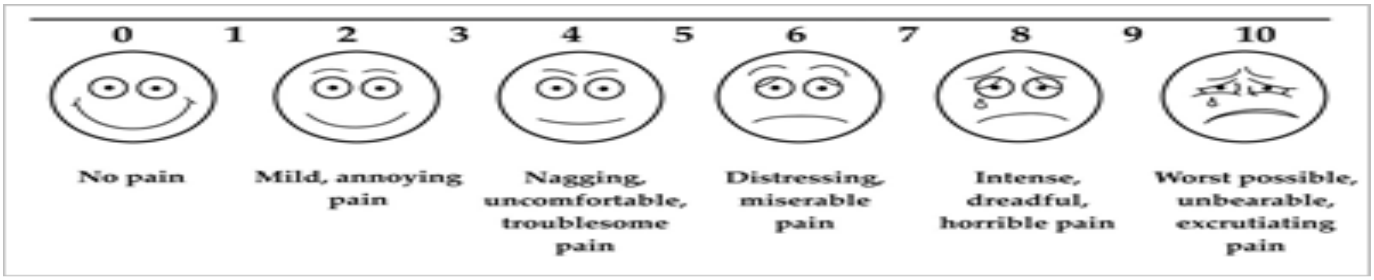
Allergies: List any medication (s) or food that you are allergic to: _____
Are you latex sensitive? Yes No

Please check (√) any of the following whose care you're under:

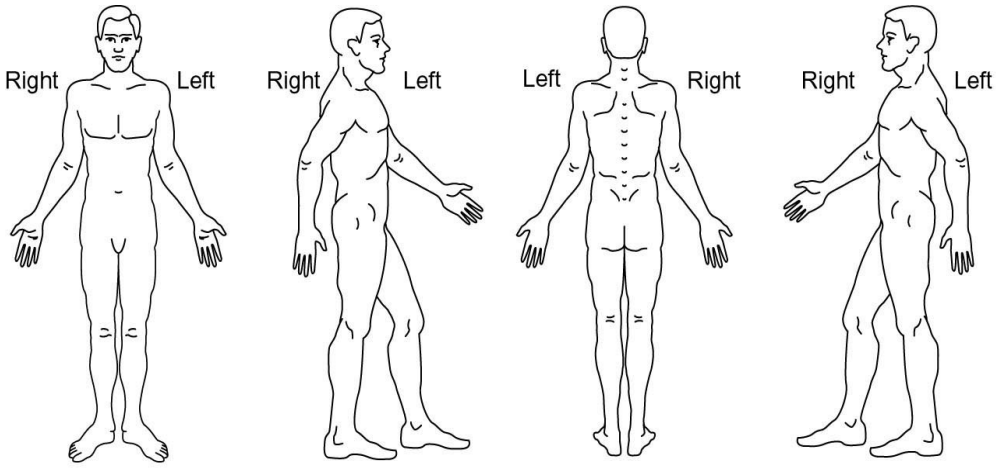
____ Medical Doctor (MD) ____ Physiatrist ____ Psychologist / Social Worker
____ Osteopath Doctor (DO) ____ Physical Therapist ____ Occupational / Speech Therapist
____ Dentist ____ Chiropractor Other: _____

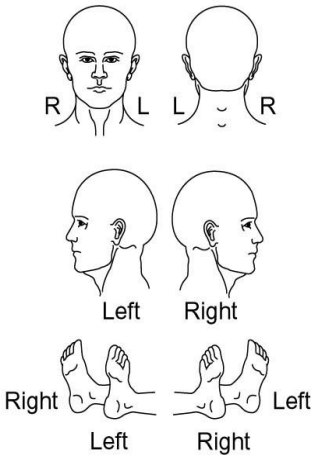
If you have seen any of the above during the past 3 months, please describe for what reason (illness, injury, physical, etc.): _____
_____

If you have pain, please indicate on the 0-10 scale below what level your pain is:



Please indicate on the diagram(s) below where your symptoms are:





Have you ever been diagnosed as having any of the following conditions?

Yes	No	Cancer	Yes	No	Epilepsy
Yes	No	High blood pressure	Yes	No	Osteoarthritis
Yes	No	Heart Disease / Problems	Yes	No	Rheumatoid Arthritis
Yes	No	Circulation Problems	Yes	No	Other Arthritic Conditions
Yes	No	Stroke	Yes	No	Multiple Sclerosis
Yes	No	Asthma	Yes	No	Emphysema / Chronic Bronchitis
Yes	No	Chemical Dependency	Yes	No	Lyme Disease
Yes	No	Thyroid Problems	Yes	No	Liver Disease
Yes	No	Diabetes	Yes	No	Tuberculosis
Yes	No	Kidney disease	Other: _____		
Yes	No	Anemia			

For Woman Only: Are you currently pregnant or think you may be pregnant? **Yes** **No**

Please list any surgeries or other conditions for which you have been hospitalized.

	Reason	Date
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please list any significant injuries that you have been treated for?

	Reason	Date
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please list any prescription medications you are currently taking:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Which of the following over-the counter medications have you taken in the last two weeks?

Yes	**No**	Aspirin	**Yes**	**No**	Antihistamine
Yes	**No**	Tylenol	**Yes**	**No**	Decongestants
Yes	**No**	Advil / Motrin / Ibuprofen	**Yes**	**No**	Antacids
Yes	**No**	Laxative	**Yes**	**No**	Vitamins / Minerals/ Supplements

Other: _____

Have you recently noted:

Yes	**No**	Weight loss / gain	**Yes**	**No**	Weakness
Yes	**No**	Nausea	**Yes**	**No**	Fever / Chills / Sweats
Yes	**No**	Fatigue	**Yes**	**No**	Numbness / Tingling

How many caffeinated beverages do you drink each day? _____
Do you have any advanced directive (Living Will, DNR, Health care proxy)? **Yes** **No**
Do you have a pacemaker or defibrillator? **Yes** **No**
Do you have a history of <u>FALLs</u>, if so how many times have you fallen down in the past year? _____,
in the past month? _____