Patient Questionnaire

UnityPoint Health
St. Luke's Hospital

Therapy Medical Information

NAME: _____ **DATE:** _____

STATEMENT: *The purpose of this form is to obtain pertinent medical information for your therapist, in coordination with your rehabilitation program.*

PAST MEDICAL HISTORY:

Major operations or hospitalizations: _____

_____

Medications currently using (including over the counter and herbals): _____

_____

Allergies: Are you allergic to any medications? ☐ Yes ☐ No If yes please document: _____
Are you allergic to latex (rubber)? ☐ Yes ☐ No
Are you allergic to Cortisone? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Have you ever had any of the following (Please X):

	Yes	No	Comments
Diabetes			
Cancer/Leukemia/Lymphoma			
High Blood Pressure			
Dizziness			
Heart Trouble			
Pacemaker			
Asthma/Emphysema/COPD			
Arthritis/Gout			
Epilepsy/Seizure			
Neurological Disease/Stroke			
Osteoporosis			
MRSA, VRE or C-diff			
Depression/Anxiety			

Are you now, or could you possibly be pregnant?	☐ Yes	☐ No
Nutrition: Have you had unexplained weight loss or gain of 10# or more in the last six months?	☐ Yes	☐ No
Do you have any questions or concerns about your diet?	☐ Yes	☐ No
Do you currently smoke?	☐ Yes	☐ No
Are you in a current relationship in which you have ever been hurt or threatened? If yes, would you like to speak with someone about this, or do you need resource information?	☐ Yes	☐ No
Are you receiving services from a Home Health Agency?	☐ Yes	☐ No
Have you fallen within the last 3 months?	☐ Yes	☐ No
Is transportation to/from therapy a concern for you?	☐ Yes	☐ No
How many physical therapy visits have you received this calendar year at any clinic?		

At the present time, would you say your health is: ☐Excellent ☐ Very Good ☐ Good ☐ Poor

How do you prefer to learn? ☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures/Visual

This information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____
Reviewed by: _____ Date: _____
Updated: _____ Date: _____
Updated: _____ Date: _____
Updated: _____ Date: _____
Updated: _____ Date: _____

PATIENT LABEL