

OUTPATIENT HISTORY

This section staff use only

VERIFY PATIENT ID (2 required) NAME DOB OTHER

ACTUAL HEIGHT & WEIGHT

DATE ___/___/___ AGE OF PATIENT Height ___ Wt. ___ N/A PREGNANT BREASTFEEDING
 Age _____ Yes No Yes No

PATIENT/FAMILY TO COMPLETE THE FOLLOWING:

I. Health Problems: Check and / or circle if you have or had any of the following?

| | Yes | | Yes | | Yes | | Yes |
|----------------------------|-----|---------------------------|-----|-----------------------|-----|-----------------------|-----|
| Diabetes | | High / Low Blood Pressure | | Difficulty Swallowing | | Depression / Anxiety | |
| Heart Problems/ Disease | | Pacemaker / AICD | | Seizures | | COPD/Pneumonia | |
| Asthma / Trouble Breathing | | Surgical Clips | | Difficulty Urinating | | Unsteady Walk / Falls | |
| Thyroid Problems | | Hepatitis / Liver Disease | | Arthritis | | Chest Pain | |
| Kidney Disease/ Dialysis | | Cancer _____ (Type) | | Stroke | | Headaches/ Dizziness | |
| Surgery | | Chemotherapy | | TIA | | Migraine | |

II. PAIN: No Yes Circle number that describes the intensity of your pain: (1-3 mild, 4-7 mod, 8-10 severe) 1 2 3 4 5 6 7 8 9 10
 Type / Quality: _____ Location: _____ Patient Stated Pain Goal (age appropriate scale 0-10) _____

III. Previous Surgeries: _____

IV. Medications: List all prescription and over-the-counter medications, herbal remedies, and/or supplements.

PLEASE PRINT CLEARLY

| Name of Medication | Dose | How Taken | How Often | Time Last Dose | Name of Medication | Dose | How Taken | How Often | Time Last Dose |
|--------------------|------|-----------|-----------|----------------|--------------------|------|-----------|-----------|----------------|
| | | | | | | | | | |
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| | | | | | | | | | |

V. Medication Allergies
 Have you had a true allergic reaction – such as 1. Red rash
 2. Hives 3. Swelling 4. Shortness of breath 5. Wheezing– to any
 drugs? No Yes If Yes, state name of medication, and indicate
 type of reaction to each: _____

VI. Medication Side Effects:
 Have you had a significant side effect – such as 1. Vomiting
 2. Upset stomach 3. Diarrhea 4. Constipation 5. Headache -
 to any drugs? No Yes If Yes, state name of medication, and
 indicate type of reaction to each: _____

VII. ALLERGIES: Have you had an allergic reaction to food or other substance? No Yes If yes, list item and reaction:

VIII. Latex Allergy:
 When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery eyes,
 wheezing, or rash? No Yes, explain: _____
 Do you have spina bifida or repeated catheterizations from congenital defects? No Yes, explain: _____
 Do you have **breathing** reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados, or cherries)?
 No Yes, explain _____

IF YES HAS BEEN CHECKED OFF ONE OR MORE TIMES, USE LATEX PRECAUTIONS
 Latex precautions indicated and initiated Latex allergy education material provided to patient

REVIEWED BY _____ PT/OT/ST FAXED TO PHARMACY

DATE: _____

Referred by: _____ Primary Care Physician: _____

Current Diagnosis/Problem: _____

Date of onset/injury: _____

Date of surgery: _____

Diagnostic Tests: (X-Ray, MRI, etc. that you have had for the above diagnosis): _____

Have you had any previous treatment for this diagnosis/problem: Yes No

Doctors seen: _____

Treatment already received: _____

Do you smoke? Yes No

Do you have any recent unplanned weight loss or gain? Yes No

Do you have any change in bowel or bladder? Yes No

Do you experience numbness or tingling? Yes No

Do you have night sweats? Yes No

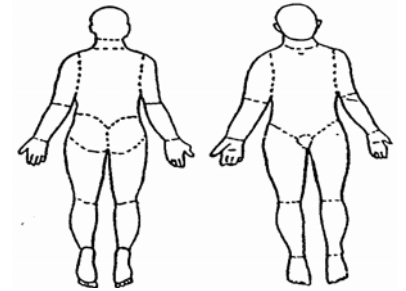
Pain: To further describe your pain that you rated on Page 1, please check the words that apply:

- | | | | |
|--------------------------------------|------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Deep | <input type="checkbox"/> Aching | <input type="checkbox"/> Pressure | <input type="checkbox"/> Nauseating |
| <input type="checkbox"/> Superficial | <input type="checkbox"/> Burning | <input type="checkbox"/> Itching | <input type="checkbox"/> Prickly |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting | <input type="checkbox"/> Pulling | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Radiating | <input type="checkbox"/> Other: | |

Mark the area of your symptom or problem on the body diagram:

Describe the pattern of your pain:

- | | |
|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Acute | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Chronic | <input type="checkbox"/> At night |
| <input type="checkbox"/> Intermittent | |



What, if anything, makes your pain worse: _____

What if anything, makes your pain better: _____

What activities do you have difficulty performing because of your wound or pain?

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Getting out of bed | <input type="checkbox"/> Driving | <input type="checkbox"/> Grooming/Dressing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Reaching High/Low | <input type="checkbox"/> Grocery shopping | <input type="checkbox"/> Housework |
| <input type="checkbox"/> Yard Work | <input type="checkbox"/> Up/Down Stairs | <input type="checkbox"/> Performing your job duties | |
| <input type="checkbox"/> Other | | | |

Are any of these affected by your problem:

- | | | | |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Ability to eat | <input type="checkbox"/> Self Image | <input type="checkbox"/> Social Interaction | <input type="checkbox"/> Bowel movement |
| <input type="checkbox"/> Urination | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Mood | <input type="checkbox"/> Sleep |

How do you learn best : oral instruction by demonstration
 by visual instruction by written instruction

What is your living situation: Alone With Family

Do you have steps/stairs in your home? _____

Hand Rails or other assistive devices? _____

What is your occupation: _____ Currently working? Yes No

OUTPATIENT HISTORY

REHAB

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TORRANCE MEMORIAL
MEDICAL CENTER

PATIENT IDENTIFICATION