John T. Mather Memorial Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

PS3550

Patient Name:_____ Date of Birth:_____ Phone: _____
Referring Physician:_____ Reason for Treatment: _____
Other Conditions:_____

Do you have a Health Care Proxy?
☐Yes If Yes Copy Requested Name: _____ Phone Number: _____
☐No If No ☐ Documents will be offered on arrival ☐Documents Declined
Upon arrival did patient bring documents ☐Yes ☐No
Current Medications (include over the counter Medications, Herbs and Vitamins): _____

SURGERY/PROCEDURE/XRAYS FOR CURRENT CONDITION	RESULTS IF KNOWN	DATE

ALLERGIES: ☐YES ☐ NO (MEDICINE, FOOD, DRUG, AND LATEX)
REACTION - EXPLAIN _____

MEDICAL HISTORY: (check box if applicable)

- ☐ **STROKES**
- ☐ **AORTIC ANEURYSM**
- ☐ **BLOOD CLOT**
- ☐ **ANEMIA**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **FRACTURES**
- ☐ **METAL IMPLANT**
- ☐ **SEIZURES**
- ☐ **HEADACHES**
- ☐ **PACEMAKER**
- ☐ **HEART DISEASE/CORONARY BYPASS**
- ☐ **CONGESTIVE HEART FAILURE**
- ☐ **HEART ATTACK**
- ☐ **COPD/EMPHYSEMA/ASTHMA**
- ☐ **BRONCHITIS**
- ☐ **DIABETES**
- ☐ **HYPOGLYCEMIA**
- ☐ **KIDNEY DISEASE/DIALYSIS**
- ☐ **ARTHRITIS/GOUT**
- ☐ **CELLULITIS LOCATION**_____
- ☐ **CROHNS DISEASE**
- ☐ **DIVERTICULITIS/COLITIS**
- ☐ **CANCER TYPE**_____
- ☐ **LYMPH NODE DISSECTION**
- ☐ **CHEMOTHERAPY**
- ☐ **RADIATION LOCATION**_____
- ☐ **OTHER**_____

1. Have you had any recent illness within the last 3 weeks (e.g. colds, influenza, bladder/kidney infection, or cellulitis)
   ☐Yes ☐ No If yes, describe _____
2. Have you noticed any lumps or thickening of skin or muscle anywhere on your body?
   ☐Yes ☐ No If yes, describe _____
3. Do you have any sores that have not healed, or any changes in size, shape or color of wart or mole?
   ☐Yes ☐ No If yes, describe _____
4. Have you had any unexplained weight loss in the last month? ☐Yes ☐ No If yes, how much? _____
5. Do you smoke? ☐ Yes ☐ No If yes, amount daily_____ Number of years_____ Have you quit_____ Date_____
6. How much caffeine do you consume daily, including soft drinks, coffee, tea or chocolate? _____
7. Are you on a special diet prescribed by a physician? ☐ Yes ☐ No If yes, explain _____
8. Have you had any unexplained pain? ☐Yes ☐ No
   If yes, what has been used (include home remedies) _____

OUTPATIENT HISTORY PHYSICAL THERAPY

CURRENT LEVEL OF FITNESS

Please describe any exercises/sport you are currently involved in: _____

_____

When did you start?_____How often _____

Are there any activities that you cannot do now that you could do before your injury or illness? If yes please describe:

_____

_____

Do you ever experience any shortness of breath or difficulty breathing (e.g. walking, climbing stairs)?

_____

_____

WORK ENVIRONMENT (Does your job involve):

Please check:

- ☐ Prolonged sitting (e.g. desk, computer, driving)
- ☐ Prolonged standing (e.g. equipment, operator, sales, clerk)
- ☐ Prolonged walking (e.g. mill worker, delivery service)
- ☐ Use of large or small equipment (e.g. telephone, forklift, typewriter, drill press, and cash register)
- ☐ Lifting, bending, twisting, climbing, turning
- ☐ Exposure to chemicals or gases

Other, please describe _____

_____

_____

What are your goals or expectations from your Physical Therapy program? _____

_____

_____

_____

Patient Information Completed by: ☐ Patient ☐ Family ☐ Other _____

Signature_____Date_____

_____ Do not write below this line _____

Therapists Comments: _____

_____

_____

_____

_____

Therapist Signature_____Date_____

Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Name: _____ Date of Birth: _____

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: _____ Date: _____

PATIENT/FAMILY SELF-REPORTED HOME MEDICATION LIST