Chan Soon-Shiong
Medical Center
at Windber

Account #: V_____ MRN: M_____
Patient Name: _____
Date of Birth: _____ Sex: _____
Service Date: _____
Attending: _____

REHAB PATIENT MEDICAL HISTORY

Start date of current symptoms: _____

Have you had Occupational or Physical Therapy in the past year?: (PLEASE CIRCLE) YES NO
If yes, please indicate date and number of visits: _____

- PLEASE CHECK IF YOU HAVE HAD ANY OF THE HEALTH CONDITIONS LISTED BELOW.

____ Cancer Type: _____
Date of surgery: _____
Number of Lymph Nodes Removed: _____

____ Radiation Treatment
____ Chemotherapy
____ Current Active Untreated Cancer
____ Deep Vein Thrombosis (Blood Clot)
____ Kidney Failure
____ Congestive Heart Failure
____ Staph Infection or other Skin infection
____ Aortic Aneurysm
____ Arterial Insufficiency
____ Venous Insufficiency
____ Heart Condition (please specify) _____
____ Pacemaker
____ Infectious/Chronic Disease (TB/Hepatitis/AIDS)
____ Reflex Sympathetic Dystrophy (RSD)
____ Post- Herpes Zoster

_____ Connective Tissue Disorder
_____ Diabetes
_____ Cellulitis
_____ Neuropathy (Numbness/Tingling)
_____ Stroke
_____ Shoulder/Elbow/Wrist Pain
_____ Neck/Back Pain
_____ Dementia/Alzheimer's
_____ Arthritis
_____ Degenerative Joint Disease
_____ Degenerative Disc Disease
_____ Joint Replacement
_____ Breathing Problems/Asthma
_____ Latex Allergy