BAYLOR
Institute for Rehabilitation
Outpatient Services

Outpatient Medical History/Screening Form Account#: _____

To be completed by the patient

Patient Name:_____ **Spoken Language**:_____

Emergency Contact:_____ **Telephone # :**_____

Family Physician/Internist:_____ **Telephone # :**_____

How can we improve the quality of your life?_____

Do you have any religious, cultural, or learning needs that we can accommodate to improve your experience?:

No ☐ Yes ☐ If yes, please explain: _____

Date of Injury:_____

Medical Information:

	YES	NO
Hypertension (high blood pressure)	☐	☐
Hypotension (low blood pressure)	☐	☐
Pacemaker	☐	☐
Emphysema /Asthma	☐	☐
Bleeding / Bruising (recent history)	☐	☐
History of diabetes	☐	☐
Hypoglycemia	☐	☐
Cancer / Tumors / Growths	☐	☐
Active seizure disorder	☐	☐
Osteoporosis	☐	☐
Swelling Of Extremities	☐	☐
Fractures	☐	☐
DATE:_____ AREA:_____	☐	☐
DATE:_____ AREA:_____	☐	☐
Artificial Joints	☐	☐
Light-Headedness / Dizziness	☐	☐
Anxiety / Panic Attacks (recent)	☐	☐
Depression(recent)	☐	☐

	YES	NO
Skin Sensitivity	☐	☐
Diminished Sensation	☐	☐
Alzheimers	☐	☐
Shortness of Breath	☐	☐
Chest Pain /Angina /Heart Attack	☐	☐
Urinary Urgency / Incontinence	☐	☐
Are You Pregnant?	☐	☐
Have you had/have a Stroke	☐	☐
Brain Injury	☐	☐
Multiple Sclerosis	☐	☐
Spinal Cord Injury	☐	☐
History of pressure sores	☐	☐
Other_____		
Are you in pain?	☐	☐
Location of pain_____		
If you answered yes to any of the above:		
Are you under the care of an MD for these conditions?	YES ☐	NO ☐

Allergies: _____

_____

Surgery(s) within last 3 months - Include Dates: _____

If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant. Advanced Directives are not honored in the Outpatient Setting.

FALL RISK ASSESSMENT*:	YES	NO
Have you fallen within the last year? If so, how many times? _____	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory/cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

AS PER CMS FALL SCREENING CRITERIA

***Patient is considered a fall risk if patient has fallen two or more times in the past year.**

***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year.**

NUTRITIONAL SCREENING:	YES	NO
Unexplained weight loss? (>5% in last 30 days)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Decrease in food intake?(<50% for 3 days or more)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

CURRENT MEDICATION: (List below)

Are all meds prescribed by a physician? Yes ☐ No ☐

*__FALL RISK__ - *Patient is considered a* fall risk *if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should refer to the Fall Prevention Policy in the OP BIR P&P manual (Policy 3.02)*

PATIENT SIGNATURE:_____**DATE:**_____

Relationship if other than patient / parent / guardian if minor:_____

This information will be used as a guide to your treatment plan.

If you need any medical follow-up, please contact your physician.

To be completed by evaluating Therapist

Patient has been identified as a fall risk : YES NO

If yes, fall prevention program has been implemented: YES NO

Patient has been identified as a nutrition risk : YES NO (If yes, notify MD)

Patient would benefit from a Social Services referral: yes no (yes - if therapist feels patient's life is threatened, or if patient is a threat to others)

Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**

(Therapist has reviewed medical history form with patient)