Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Patient Identifier Here

Department of Rehabilitation Services, Lexington
Health Status Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete BOTH sides of this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Age: _____ **Height**: _____ **Weight**: _____

Why did you come to see the therapist today? _____

_____

Have you ever been told that you have:

High Blood Pressure	Yes/No
Heart Problems	Yes/No
Lung Problems	Yes/No
Kidney Problems	Yes/No
Thyroid Problems	Yes/No
Ulcers/Stomach Problems	Yes/No
Diabetes/High Blood Sugar	Yes/No
Low Blood Sugar	Yes/No
Tuberculosis	Yes/No
Circulation/Vascular Problems	Yes/No
Osteoporosis	Yes/No
Broken Bones/Fracture	Yes/No
Arthritis	Yes/No
Cancer	Yes/No
Head Injury	Yes/No
Stroke/Neurologic Problems	Yes/No
Multiple Sclerosis/Parkinson's	Yes/No

For MEN Only:

Prostate Disease	Yes/No

For WOMEN Only:

Trouble with Your Period	Yes/No
Endometriosis	Yes/No
Pregnancy/Delivery Complications	Yes/No
Are You Pregnant, Think You Might Be	Yes/No

Have You RECENTLY Had:

Weight Loss/Gain	Yes/No
Loss of Appetite	Yes/No
Pain at Night	Yes/No
Fever/Chills/Sweats	Yes/No
Difficulty Sleeping	Yes/No
Joint Pain/Swelling	Yes/No

Have you RECENTLY Had:

Urinary or Bowel problems	Yes/No
Nausea and Vomiting	Yes/No
Numbness and Tingling	Yes/No
Weakness in Arms or legs	Yes/No
Coordination problems	Yes/No
Difficulty Walking	Yes/No
Dizziness	Yes/No
Visual Problems	Yes/No
Headaches	Yes/No
Loss of Balance	Yes/No
Hearing Problems	Yes/No
Chest Pain	Yes/No
Shortness of Breath	Yes/No
Difficulty Swallowing	Yes/No
Do you have any significant family history of illness or disease?	Yes/No
Do you have any other medical problems? Please List:	
Do you take any medication (prescription or non-prescription)	Yes/No
If yes, please list:	
Do you have any allergies?	Yes/No
Have you had any surgery or been hospitalized in the past?	Yes/No

PLEASE TURN SHEET OVER

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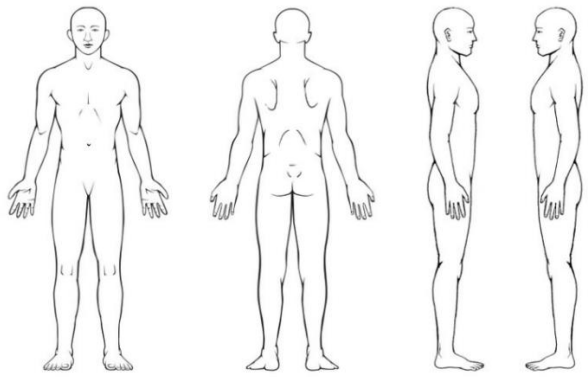
YOUR PAIN: Please indicate where you have pain by marking Drawing below with an 'X'.

Therapist's Comments:



Place an 'X' on the line below to indicate pain level:

No Pain_____Worst Pain

Have you recently had any of the following tests? Check all that apply.

____X-Ray	____MRI	____Bone Scan
____CT Scan	____Blood Test	____EKG
____EMG	____Myelogram	____Echocardiogram
____Stress Test	____Other, please list:_____	

Have you seen anyone else for this problem? Check all that apply.

____PCP/NP	____Orthopedist	____Neurologist
____Podiatrist	____Chiropractor	____Dentist
____Acupuncturist	____Other Specialist, please list:_____	

Who is your PCP and referring doctor (if different):_____
When was your last general health check-up? _____

Have you ever been emotionally, physically, or sexually hurt by your partner or someone important to you? _____Yes/No
Do you have any cultural or religious preferences you would like us to be aware of? _____Yes/No

_____
Patient Signature **Date**

_____
Therapist Signature **Date**

PLEASE TURN SHEET OVER