ORLANDO HEALTH®

Mailing Address: 1414 Kuhl Ave. • Orlando, FL 32806

LINE UP PATIENT I.D. LABEL HERE

ORLANDO HEALTH REHABILITATION SERVICES OUTPATIENT HISTORY

We are a 911 facility. In the event of an emergency 911 will be contacted.

Emergency contact information: Name: ______________________________

Relationship to the patient ____________________ Phone Number: ____________________

Are you currently receiving ANY Home Health Services? ☐ **Yes** ☐ **No**

If yes please do not complete the rest of this form before speaking with a representative at the front desk.

Do you have any of the following?

☐ Advanced Directives ☐ Living will ☐ DNR ☐ Medical Power of Attorney

TO BE COMPLETED BY STAFF: Copy of above provided by patient ☐ Yes ☐ No

If patient does not have any of the above was education provided ☐ Yes ☐ No

Education on above provided by: ____________________ date: __________ time: __________

☐ Education declined by: ____________________ date: __________ time: __________

Have you been an inpatient or outpatient at an Orlando Health facility before? ☐ Yes ☐ No

If yes, where ______________________________

Medical History: Please check all that apply

☐ High Blood Pressure
☐ Heart Condition
☐ Diabetes
☐ Fainting Spells
☐ Stroke
☐ Seizures
☐ Vascular problems
☐ Emphysema/Bronchitis
☐ Hepatitis
☐ Thyroid problems
☐ Cancer
☐ Dizziness
☐ Blood clots
☐ Osteoporosis/Osteopenia
☐ HIV +/AIDS
☐ Urinary problems
☐ Chemotherapy
☐ Radiation
☐ Other ______________________________

Are you having difficulty with?

☐ Sleeping
☐ Caring for self
☐ Working
☐ Social Activities
☐ Housework
☐ Yard Work
☐ Communication
☐ Swallowing
☐ Memory
☐ Other ______________________________

Do you react abnormally to Heat ☐ Yes ☐ No **Cold** ☐ Yes ☐ No

Are you pregnant? ☐ Yes Due date: ____________________ ☐ No ☐ Maybe

Do you have metal in your body? ☐ Yes ☐ No Where? ____________________

Do you have a pacemaker? ☐ Yes ☐ No

Do you have any artificial joints? ☐ Yes ☐ No Where? ____________________

Are you currently working? ☐ Yes ☐ No Occupation? ____________________

Reviewed by (Staff Signature): ____________________ Date: __________ Time: __________

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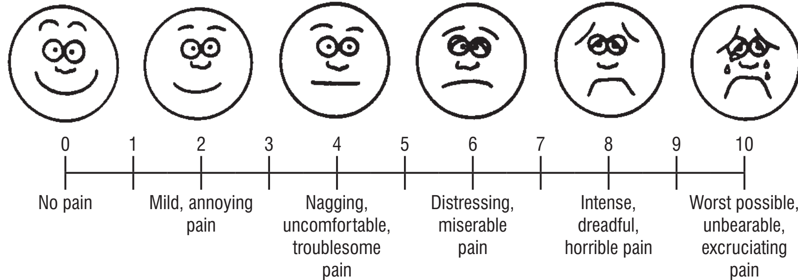
What is your preferred learning style? ☐ **Visual** ☐ **Listening** ☐ **Both** ☐ **Other** ____________________

Please rate your current pain



IMPORTANT PLEASE DO NOT SKIP

1. Is there history of or current sexual, emotional, or physical abuse? ☐ No ☐ Yes:
   History of Current

If yes the staff can give you information

2. Have you recently changed your eating habits?
   ☐ Yes ☐ No
3. Do you have any social/emotional concerns?
   ☐ Yes ☐ No

If yes to 2 or 3 Please explain: ________________

____

____

Recent Exposure to Communicable Diseases:

☐ Yes ☐ No If Yes, please specify:

Chicken Pox Measles Mumps Other

History of MRSA/VRE (multi-drug resistant organisms): ☐ Yes ☐ No

* initiate MRSA/VRE Protocol orders # 5872-96739

TB Screening (including patients 12 or older)
Check each box that the answer is YES

☐ (3 points) Cough for longer than 2 weeks

☐ (5 points) Blood in the sputum

☐ (2 points) Fevers of night sweats

☐ (2 points) Recent unexplained weight loss of more than 10 lbs.

☐ (2 points) Recent exposure to TB

☐ (5 points) History of TB or active TB (even if on meds)

☐ (2 points) Jail in the past 2 years

☐ (2 points) HIV positive

☐ (1 point) Homeless or living in a shelter

☐ (1 point) Foreign born (Asia, E. Europe, Latin America, Africa)

Total Points: _______

Notice: In the event that your insurance benefits have been exhausted, you may continue your therapy (self-pay). Payment is required at the time services are rendered.

Patient/Patient
Representative Signature: ______________________________ Date: ____________ Time: __________

Reviewed by (Staff Signature): ______________________________ Date: ____________ Time: __________