NORTH HAWAII
COMMUNITY HOSPITAL

PRE-EVALUATION SCREENING QUESTIONNAIRE
Rehabilitation Services Department

Patient Name:	**DOB:** **Today's Date:**
Occupation:	**Leisure Activities/Hobbies:**
Diagnosis:	**Height:** **Weight:**

Are you currently seeing any of the following?

Medical doctor (M.D.)	**YES**	**NO**	**Psychiatrist/Psychologist**	**YES**	**NO**	**Osteopath**	**YES**	**NO**
Chiropractor	**YES**	**NO**	**Acupuncturist**	**YES**	**NO**	**Neurologist**	**YES**	**NO**
PT/OT/ST and/or MT	**YES**	**NO**	**Naturopathic doctor**	**YES**	**NO**	**Dentist**	**YES**	**NO**
Ophthalmologist	**YES**	**NO**	**Orthopedist**	**YES**	**NO**	**OB/GYN**	**YES**	**NO**

If you have seen any of the above during the past three months, please describe for what reason.

_____

_____

Recent diagnostic tests (X-ray, MRI, US, CT, Bone Scan, Labs):_____

Have you ever been diagnosed as having any of the following conditions?

YES NO Cancer, if YES describe what kind: _____
YES NO Heart Problems/Murmur
YES NO Circulation problems/Clots
YES NO High blood pressure
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical dependency (i.e. alcoholism, etc.)
YES NO Thyroid problems
YES NO Diabetes (Type I, II, or Gestational)
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions (Gout)
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy/Seizures
YES NO Osteoporosis/Osteopenia
YES NO Urinary Incontinence
YES NO Bowel/Bladder Problems
YES NO Other: _____.

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	**SURGERY/HOSPITALIZATION**	**REASON**

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	**INJURY**	**DESCRIPTION OF INCIDENT**

Do you currently participate in an exercise program? _____ How much? _____ How Often? _____
How many caffeine containing beverages do you drink per day? _____
Do you use tobacco? _____ How much? _____ How Often? _____
Do you drink alcohol? _____ How much? _____ How Often? _____
Other types of substances or drugs:_____
During the past month have you been feeling down, depressed or hopeless? YES NO

Have you had any thoughts of taking your life in the past 2-3 months? YES NO

Please explain: _____

Are you under physical or emotional abuse, feel unsafe at home or has anyone hit you or tried to injure you in anyway? YES NO

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart disease
YES NO High blood pressure

THERAPIST USE:

Vitals: BP_____/_____
HR_____bpm
O2 Sat_____
RR_____

YES NO Stroke
YES NO Kidney disease
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental illness
YES NO Alcoholism (chemical dependency)

Have you recently (within the last 3 months) experienced?

YES	**NO**	**Weight loss/gain**	**YES**	**NO**	**Shortness of Breath/Persistent Cough**
YES	**NO**	**Nausea/vomiting**	**YES**	**NO**	**Recent Infection (Cold, flu, bladder, kidney)**
YES	**NO**	**Fatigue**	**YES**	**NO**	**Difficulty swallowing/speaking**
YES	**NO**	**Weakness**	**YES**	**NO**	**Falls**
YES	**NO**	**Fever/chills/sweats (AM/PM)**	**YES**	**NO**	**Change in bowel/bladder function, appearance**
YES	**NO**	**Dizziness/Fainting/Blackouts**	**YES**	**NO**	**Confusion or Memory Problems**

Female patients please answer:

YES NO Endometriosis
YES NO History of pelvic inflammatory disease
YES NO Are you/ could you be pregnant?
YES NO Pre/post menopause

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HOME MEDICATIONS LIST

List any known food, drug or environmental allergies you have: _____

_____

_____

❑ **No known allergies** **Are you allergic to Latex? Yes No**

Which of the following OVER THE COUNTER medications have you taken in the last week?

Medication			Dose	Frequency	Comments
Aspirin	**Y**	**N**			
Tylenol	**Y**	**N**			
Advil/Motrin/Ibuprofen	**Y**	**N**			
Laxatives	**Y**	**N**			
Decongestants	**Y**	**N**			
Antihistamines	**Y**	**N**			
Antacid	**Y**	**N**			
Vitamins/mineral supplements	**Y**	**N**			
Other:					

List any PRESCRIPTION medication you are currently taking (including pills, injections, and/or skin patches):

❑ ***I currently do not take any prescription medication(s)***

Medications	Dose	Frequency	Comments

Source of Medication List (family, patient, EMR, Pharmacy, Rx Vials, etc.):_____

_____

Patient's Signature ***Date*** ***Physical Therapist's Signature*** ***Date***