

## Baylor Rehabilitation System Outpatient Medical Profile / Summary List

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Daytime contact phone numbers: \_\_\_\_\_ cell/work/home? \_\_\_\_\_

\_\_\_\_\_ cell/work/home? \_\_\_\_\_

Daytime e-mail address: \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Do you have any medical conditions related to the following?

Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lungs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone/Joint Injuries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary or Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness or Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Balance Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any of the above, please explain: \_\_\_\_\_

Do you have any other medical conditions that you think we should know about?  Yes  No

If yes, please explain: \_\_\_\_\_

Please list any significant operations and dates they occurred:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list additional procedures on page 3

Does patient have advanced directives for medical care?  Yes  No

If yes, is a copy available to file in the chart?  Yes  No

If a copy is unavailable please make a note of this in the chart.

Do you have any diet/liquid restrictions?  Yes  No

If yes, please list: \_\_\_\_\_

Do you have pain?  Yes  No

If yes, where is your pain? \_\_\_\_\_

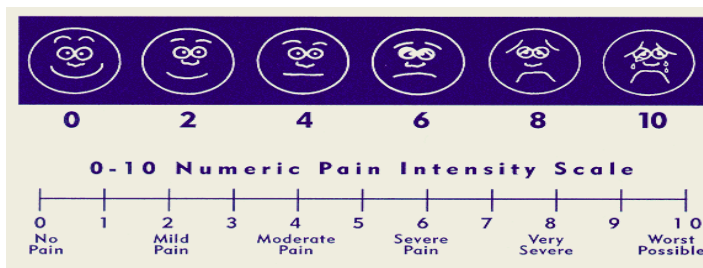
Is your pain constant?  Yes  No

What relieves your pain? \_\_\_\_\_

On a scale of 0 to 10 how would you rate your pain?

(please circle)

0 1 2 3 4 5 6 7 8 9 10



**BAYLOR INSTITUTE FOR REHABILITATION**



BIR-50058 (Rev. 04/07)

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Have you had any falls?  Yes  No

If yes, when: \_\_\_\_\_ where: \_\_\_\_\_

Do you use a cane or walker to help you walk?  Yes  No \_\_\_\_\_

What other equipment do you use on a regular basis to help your function: \_\_\_\_\_

Are you receiving any other care for your condition: \_\_\_\_\_

Have you been discharged from a hospital or received home health care within the last 30 days? If so, please list dates: \_\_\_\_\_

Have you received therapy for the same condition within the last year?  Yes  No

At the present time would you say your health is:  Excellent  Very Good  Fair  Poor

Where do you intend to live at the conclusion of this outpatient therapy episode: \_\_\_\_\_

Who will you live with at the conclusion of this outpatient therapy episode: \_\_\_\_\_

### Outpatient Learning Needs

**Learning Needs:** Are there any factors below, which would affect the patient's ability to learn?

Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reading	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Writing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Language	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comprehension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cultural	<input type="checkbox"/> Yes <input type="checkbox"/> No
Religious	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter Needed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Limited Attention Span	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If you answered yes to any of the above, please explain: \_\_\_\_\_

Name and relationship of Alternate/Additional Learners: \_\_\_\_\_

**Age group of patient:** (*please circle one*) (yr = years; yrs = years)

Infancy	(birth-1 yr)	School Age	(6-12 yrs)	Middle Adulthood	(45-65 yrs)
Toddler	(1-3 yrs)	Adolescence	(12-18 yrs)	Late Adulthood	(66-79 yrs)
Pre-School	(3-6 yrs)	Early Adulthood	(19-45 yrs)	Late-Late Adulthood	(80 yrs-up)

**Patient learns best by:** (*please circle all that apply*)

Verbal	Written	Demonstration	Practice
Instructions	Instructions		

Medication Allergies?  Yes  No

If yes, please list: \_\_\_\_\_



