Glen Cove Hospital
Northwell Health℠

PATIENT QUESTIONNAIRE

DATE _____

Patient Name _____ DOB _____ Age ____ Sex: □ Male □ Female
Street Address _____ Town _____ State: _____ Zip Code _____
Home Phone # _____ Cell # _____ Work # _____
Marital Status: □ Single □ Divorced □ Married Spouse's Name: _____
Highest Level of Education: _____ Preferred Language: _____
Occupation _____ Place of Employment _____ □ Full Time □ Part Time
Referring Physician/Surgeon _____ Phone # _____
Primary Physician _____ Phone # _____
Primary Insurance Company _____ Secondary Insurance Company _____
Emergency Contact _____ Relationship _____ Phone # _____

Please answer the following questions to the best of your ability:

MEDICAL

1. Please **check off** any medical history as it applies to you and **write the date** diagnosed:
□ Anxiety: _____ □ Atrial Fibrillation: _____ □ Asthma: _____ □ Blood Clots: _____
□ COPD/Emphysema: _____ □ Depression: ____ □ Diabetes (circle): Type 1 Type 2 □ Defibrillator ___
□ Gout: ____ □ Heart Attack: ____ □ High Blood Pressure: ____ □ Low Blood Pressure: _____
□ Lyme Disease: _____ □ Multiple Sclerosis: _____ □ Neuropathy: _____ □ Osteoporosis: _____
□ Osteoarthritis: _____ □ Pacemaker: _____ □ Pneumonia: _____ □ Psychiatric: _____
□ Rheumatoid Arthritis: ____ □ Stroke/TIA: _____
□ Cancer (circle): Breast Lung Head/Neck Ovarian Prostate Spine Other: _____ Date: _____
□ Other (if not listed above):_____
2. Please list your **ENTIRE** surgical history: _____
_____
_____
3. Have you ever had a Total Joint Replacement? □ No □ Yes: Which body part? _____
When? _____
4. **Allergies:** □ No □ Yes, please list: _____
_____
5. Please list **ALL** medications you are currently taking: _____
_____
6. Did you stay overnight in the hospital recently (past 6 months)? □ No □ Yes When? _____
7. Were you ever placed on "isolation" at a hospital? □ No □ Yes
If yes, when?_____ Why? _____
8. Have you fallen recently (past 6 months)? □ No □ Yes: When? _____
Were you hospitalized because of your fall? □ No □ Yes: Where/When?_____
9. Which hand dominant are you: □ Right □ Left □ Ambidextrous
10. Do you have any vision problems? □ No □ Yes _____
11. Do you wear a hearing aide? □ No □ Yes: since when? _____
12. Have you ever had a hearing test? □ No □ Yes: Where? _____ When? _____

INSURANCE

13. Were you involved in a **motor vehicle accident**? □ No □ Yes: Date of accident: _____
14. Is this injury/problem **work-related**? □ No □ Yes: Date of injury: _____
15**. MEDICARE** patients: Have you had any outpatient PT, OT or Speech therapy since January of this year? □ No □ Yes: How many visits of each? _____ Where? _____

PERSONAL LIVING SITUATION

16. Do you live in: □ House □ Apartment □ Care Facility □ Other _____
17. Do you have stairs at home? □ No □ Yes: How many? _____
18. I live: □ Alone □ With Family: List who you live with: _____
□ Aide: □ Live-in □ Part-time □ Other: _____
19. Do you drive? □ No □ Yes, but not currently, since injury/problem □ Yes, currently driving
20. Do you work? □ No □ Yes: Do you plan on returning to work? □ No □ Yes: When?: _____
21. How did you hear about our therapy clinic? □ Doctor: _____ □ Friend: _____
□ Website □ Brochure □ Newsletter □ Other: _____

I certify the above information is true to the best of my knowledge and ability.

_____
Patient/Representative Print Name

_____ _____ _____
Patient/Representative Signature Relationship Date