



Patient Name: _____ **Date of Birth:** _____

Type of Surgery: _____ **Surgeon:** _____

Height: _____ **Weight:** _____

Best number to reach you at: _____ **Email:** _____

Allergies: None

List all allergies and reactions: _____

List all past surgeries & dates: None

Primary Care Physician: _____ **Date last Seen:** _____

Specialists: _____

Patient Sticker



HOME EVALUATION



Patient Name: _____ Date of Birth: _____

Type of Surgery: _____

Living Situation/ Home Set up (CIRCLE all that apply)

1. My hometown is: _____
2. I live with: Alone Family Friend/Roommate Spouse/Significant other Caretaker
3. My Home is a(n): One Level Split Level 2-Story Apartment
Nursing Home Assisted living Correctional facility Other
4. How many stairs are there to enter your home: _____
5. Are there handrails at the entrance: On left going up On right going up
Both sides None
6. How many stairs are there inside your home: _____
7. Is there a bedroom on the main floor: Yes No
8. Is there a bathroom on the main floor: Yes No
9. Equipment I Currently Have: Cane Knee walker Wheelchair Portable commode
Shower chair 4-Wheeled walker Walker Oxygen Crutches
Dressing equipment Hospital bed Toilet seat riser
10. My bathroom currently has: Tub/shower Walk-in shower Tub only Walk-in tub
Shower curtain Shower door Grab bars
11. The toilet is: Standard height High rise toilet Other
12. Prior level of function
 - a. Do you need help getting dressed or bathing? Yes No
 - b. Do you need help with walking or with stairs? Yes No
 - c. Do you complete your own cooking, cleaning, laundry, & shopping? Yes No
 - d. Do you drive? Yes No

Patient Sticker

