DriveAbility
Exeter Hospital
4 Alumni Drive, Exeter, NH 03833
O (603) 580-7927
F (603) 580-7931
driveability@ehr.org

Name: _____
Date of Birth: _____
Today's Date: _____

Case History/Summary List

Medical History

Known Drug Allergies:				**Medications Currently Taken:**	Dose	Freq
	Don't Know	***Yes***	***No***			
Are you allergic to latex?	☐	☐	☐			
Any other allergies? (pollen, dust, etc.)		☐	☐			
• If yes, explain:				**Please answer the following:**	***YES***	***NO***
Any food allergies?		☐	☐	Do you use any assistive devices?	☐	☐
• If yes, explain:				(cane, splint, wheelchair) Explain:		
Are you pregnant?	☐	☐	☐	Left Handed ☐ Right Handed ☐		
Immunizations current?(Pts. under age 15)	☐		☐			

Have you ever been hospitalized? ☐ Yes ☐ No

- If **Yes**, please list all hospitalizations below.

Reason: _____ Year: _____

_____ _____

_____ _____

Please check any of the conditions/diseases you have had or now have, and give date of onset:

	Date		Date		Date
☐ Diabetes		☐ Stroke		☐ Epilepsy/Seizures	
☐ High Blood Pressure		☐ Fractures/Broken Bone		☐ Cancer	
☐ Heart Disease/Attack		☐ Osteoporosis		☐ Fever	
☐ Pacemaker		☐ Pneumonia		☐ Night sweats	
☐ Migraine Headaches		☐ Asthma		☐ Communicable disease	
☐ Concussion/Head Injury		☐ Gynelogical Problems		☐ Incontinence	
☐ Metal Implants		☐ Lung Disease		☐ Eye/Vision Problems**	
				☐ Other_____	

Social History

How do you learn best? ☐ Seeing ☐ Hearing ☐ Doing

Is English your primary language? ☐ Yes ☐ No If **No**, what language?

Do you smoke? ☐ Yes ☐ No How many packs per day?

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day?

Are you in a relationship where you have been hurt or threatened in any way? ☐ Yes ☐ No

Are there any religious/cultural needs pertinent to your treatment? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No If **Yes,** do you receive assistance & from whom? _____

Nutrition:	Have you had a recent wt loss or gain >10 pounds? ☐ Yes ☐ No
	Have your dietary habits changed recently? ☐ Yes ☐ No

Please check any of the following Community Resources that may be of potential use: ☐ N/A

☐ Meals on Wheels ☐ Homemaker ☐ Home Health Aide ☐ Transportation ☐ Lifeline ☐ **Other**

***Drive*Ability**
Exeter Hospital
4 Alumni Drive, Exeter, NH 03833

Name: _____
Date of Birth: _____
Today's Date: _____

Current Injury/ Problems:	
Onset Date:	
Prior Level of Function:	

Has your current condition affected your ability to perform any of the following? Please check all that apply:

- ☐ **Personal Care (bathing, dressing, grooming)**_____
- ☐ **Reaching (overhead, behind back, out to side)**_____
- ☐ **Getting in/out of bed, chair, car):**_____
- ☐ **Sleep/bed mobility:**_____
- ☐ **Sitting/driving (how long):**_____
- ☐ **Standing (how long):**_____
- ☐ **Walking (how far):**_____
- ☐ **Climbing Stairs:**_____
- ☐ **Lifting/bending:**_____
- ☐ **Family/Household responsibilities:**_____
- ☐ **Work duties:**_____
- ☐ **Leisure/recreational activities:**_____

Currently Employed? ☐ Yes ☐ No Occupation: _____

**** Please describe any eye/vision problems you may have:** _____

Driving History (if applicable):

Driver's License #: _____ **Expiration Date:** _____

Have you ever attended Driver Education classes? ☐ Yes ☐ No

If yes: When:_____ Where:_____
Date Completed:_____ If not completed, why?_____

Please list and describe any accidents or traffic violations you have experienced:

_____
_____
_____
_____

Have you been evaluated for driving before? ☐ Yes ☐ No

If yes: When:_____ Where:_____

Please describe the vehicle you will be driving most:
Make:_____ Model:_____
Automatic or Standard:_____ 4 door or 2 door:_____

Options/Accessories:_____

Patient History completed by: _____
Reviewed by: _____