PT-Form F

Ottawa County Health Center- Minneapolis, KS
Rehabilitation Department Medical History Questionnaire

Name _____ Date_____

DO YOU HAVE NOW (OR HAVE YOU HAD) ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Cancer	☐	☐	Speech / Swallowing Problems	☐	☐
Pacemaker	☐	☐	Hard of Hearing	☐	☐
Diabetes	☐	☐	Fibromyalgia	☐	☐
Stroke	☐	☐	Depression	☐	☐
Metal Implants	☐	☐	Anemia	☐	☐
Osteoporosis	☐	☐	Unexplained Weight Loss / Gain	☐	☐
Dizziness / Lightheadedness	☐	☐	High Blood Pressure	☐	☐
Heart Disease	☐	☐	Low Blood Pressure	☐	☐
Asthma	☐	☐	Shortness of Breath	☐	☐
Seizures	☐	☐	Headaches	☐	☐
Vision Problems	☐	☐	Parkinson's	☐	☐
Multiple Sclerosis	☐	☐	Osteoarthritis	☐	☐
Low Blood Sugar	☐	☐	Rheumatoid Arthritis	☐	☐

Are you currently pregnant	☐	☐	Do you smoke	☐	☐

1. What medications are you currently taking? _____

_____

2. Have you had any special tests recently (past 3 months)
_____X-ray ____CT scan _____MRI _____EMG _____Bone scan _____Blood test _____Other
Do you know the results of any special tests? Y / N if yes, please describe_____

_____

3. Have you ever had surgery before? Y / N if yes, please describe_____

_____

4. Have you fallen in the last 3 months? Y / N if yes, please describe_____

_____

5. Have you ever had a broken bone? Y / N If yes, where _____

6. Do you have any allergies to tape adhesives or latex? Y / N _____

7. Are you currently receiving home health services? Y / N _____

8. Are you currently receiving hospice services? Y / N _____