MADONNA THERAPYPLUS
Physical and Occupational Therapy
An outpatient clinic of Madonna Rehabilitation Hospital

Medical History Questionnaire

Condition requiring therapy? ______________________________

What goals are you hoping to achieve with therapy? ______________________________

Have you had recent treatments for this condition? ______________________________

Who is your Primary Care Physician? ______________________________

When is your next doctor appointment? ______________________________

Work status? ☐ Not Working ☐ Light Duty ☐ Full Duty

Heart and Blood Vessels							
Have you ever had?	Y	N	Year	**Have you ever had?**	Y	N	Year
Heart Attack				Heart Surgery			
Chest Pains				Pacemaker			
Stroke				Angioplasty			
High Blood Pressure				Stents			
High Cholesterol				Kidney Failure			
Dizziness				Arrhythmias			
Aneurysm				Blood Clots			
Bone, Muscle and Nerve Conditions							
Have you ever had?	Y	N	Year	**Have you ever had?**	Y	N	Year
Osteoporosis				Meniscus Injury			
Osteopenia				Fibromyalgia			
Arthritis				Herniated Disc-Neck			
Fractures				Herniated Disc-Back			
Brain/Head Injury				Multiple Sclerosis			
Whiplash				Carpal Tunnel			
Gout				Rheumatoid Arthritis			
Polio				Joint Dislocations			
Lung/ Pulmonary Conditions							
Have you ever had?	Y	N	Year	**Have you ever had?**	Y	N	Year
Shortness of Breath				COPD			
Asthma				Pneumonia			
Emphysema				Allergies			
Other Conditions							
Have you ever had?	Y	N	Year	**Have you ever had?**	Y	N	Year
Diabetes				Cancer			
Neuropathy				Hepatitis C			
Thyroid Imbalance				Communicable Diseases			
Depression				Seizures			
Blurred Vision				Hysterectomy			
Deafness				Urinary Incontinence			
Frequent Falls				West Nile Virus			
Unsteady Balance				Bleeding Disorders			
Numbness In Face, Hands or Legs				Children or Been Pregnant			

Patient Name____ Date of Birth __________
(please print)

Patient Signature____________________________________ Date__________ Time________

Other conditions, injuries, surgeries, hospitalizations, x-rays, MRIs, special testing?			
Condition	**Year**	**Condition**	**Year**

Allergy Information	
Latex allergy ? ☐ Yes ☐ No	
Other Allergies:	**Type of Reaction :**

Medication Information			
Medication Name	**Reason for Taking Medication**	**Prescribing Physician**	**Physician Phone Number**

☐ See attached medication list, which includes the physician name and telephone number.

Patient Name: ____ Date of Birth __________
(please print)

Patient Signature: _________________________________ Date ______________ Time________