The Sigurd Center for Orthopedic & Neurological Rehabilitation

1311 Augusta Road West Columbia, SC 29169

P: 803.926.7204 F: 803.926.7206

www.sigurdphysicaltherapy.com

Medical History Questionnaire

Patient Name:__________________________DOB:____________________Date of Injury/Onset:_________________________

Have you ever received therapy before? YES NO If so, When:__________________Facility:_________________

Are you pregnant or could you be pregnant? YES NO N/A

Do you now have or have you ever been diagnosed with any of the following:

	YES	NO		YES	NO
Pacemaker	______	______	High Blood Pressure	______	______
Seizures/Epilepsy	______	______	Heart Disease	______	______
Metal Implants	______	______	Weight loss/gain	______	______
Cancer/Tumor	______	______	Current Infection	______	______
Defibrillator	______	______	Tuberculosis	______	______
COPD	______	______	Hepatitis	______	______
CHF	______	______	Thyroid Problems	______	______
Arthritis	______	______	Headaches	______	______
Stents	______	______	Head Injury	______	______
Anemia	______	______	Heart Attack	______	______
Cardiac Surgery	______	______	Swelling in ankles	______	______
Vascular Disease	______	______	Visual Deficits	______	______
Stroke	______	______	Hernia	______	______
Asthma	______	______	Previous Surgery	______	______
Hearing Loss	______	______	Previous Fracture	______	______
Osteoporosis	______	______	Depression	______	______
Substance Abuse	______	______	Anxiety	______	______
Fainting Spells	______	______	Chronic cough	______	______
Diabetes	______	______	Allergies	______	______
Deep Vein Thrombosis	______	______	Shortness of Breath	______	______
			Hypersensitivity to Heat/Cold	______	______

If you answered yes to any of the above, please explain and give approximate date(s):

____

____

____

Are you currently taking any medications? YES NO If so, please list all medications on medication log

Patient/Parent Signature:____Date:_______________________________________