Grand River Physiotherapy

Medical History Questionnaire

Name:_____ **Date:**_____
Age:_____ **Date of Birth:**_____ **Family Doctor:**_____

Emergency Contact Person:_____ **Relationship:**_____
Phone #: (____)_____

Medical/Surgical History

Please indicate any conditions for which you have been treated for (currently or in the past):

Heart Disease	yes	no	Head Injury	yes	no
Circulatory Problems	yes	no	Cancer/Leukemia	yes	no
Diabetes Mellitus	yes	no	Infectious Disease	yes	no
DVT (blood clots)	yes	no	Osteoporosis/Osteopenia	yes	no
Blood disorder or hemophilia	yes	no	Thyroid Problems	yes	no
Anemia	yes	no	Seizures	yes	no
High or Low Blood Pressure	yes	no	Stroke/TIA	yes	no
Lung Problems	yes	no	Gout	yes	no
Rheumatic Fever	yes	no	Prolonged Steroid Use	yes	no
Arthritis (Osteoarthritis/Rheumatoid)	yes	no	TB	yes	no
Liver Disease (jaundice, hepatitis,etc)	yes	no	Asthma	yes	no
Kidney Disease	yes	no	Cervical Trauma/Whiplash	yes	no
Stomach Disease	yes	no	Significant Trauma/Illness	yes	no
Bacterial Endocarditis	yes	no	Balance Problems/Frequent Falls	yes	no
Epilepsy	yes	no	Artificial Joints	yes	no
Hypo/Hyperglycemia	yes	no	Implants (Pacemaker, etc)	yes	no

List any other medical conditions that have not already been listed: _____

_____

Review of Systems

*Please indicate any of the following which you are **currently** experiencing:*

Joint Stiffness or swelling	yes	no	Numbness/Tingling	yes	no
Ringing/buzzing in ears	yes	no	Pain radiating down arm/leg	yes	no
Visual Changes	yes	no	Tingling in arm/leg	yes	no
Chest Pain	yes	no	Headaches/migraines	yes	no
Persistent Cough	yes	no	Shortness of breath	yes	no
Abdominal pain/bloating	yes	no	Nausea/Vomiting	yes	no
Fever	yes	no	Depression	yes	no
Difficulty swallowing	yes	no	Urinary Incontinence	yes	no
Fainting	yes	no	Bowel Dysfunction	yes	no
Visual Disturbances	yes	no	Lack of Appetite	yes	no
Loss of consciousness	yes	no	Night sweats	yes	no
Unexplained weight loss/gain	yes	no	Night Pain	yes	no
Pregnancy	yes	no	Skin rash	yes	no
Do you smoke?	yes	no			

Please list any allergies you have:_____

For completion by the physiotherapist.
Comments: _____

Medical History Update:Date **Comments**
Signature

_____
_____
_____