BIGHORN
PHYSICAL THERAPY AND SPORTS MEDICINE, P.C.

Medical History Questionnaire

Name: _____ **Date of Evaluation:** _____
Sex: M F **Date of Birth:** _____ **Age:** ____ **Occupation:** _____

Allergies:
Please list any allergies you may have:_____
Latex Allergy? Y N How Severe? _____

Past Medical History

Cancer	Y N	Osteoporosis	Y N	Migraines	Y N
Pacemaker	Y N	Rheumatoid Arthritis	Y N	Vertigo	Y N
High Blood Pressure	Y N	Joint Replacement	Y N	Multiple Sclerosis	Y N
Heart Disease	Y N	Mental Illness	Y N	Parkinson's Disease	Y N
Heart Surgery	Y N	HIV	Y N	COPD	Y N
Stroke	Y N	Hepatitis C	Y N	Asthma	Y N
Chest Pain	Y N	Diabetes Type 1 or 2	Y N	Dislocations	Y N
Blood Clots	Y N	Seizures	Y N	Dementia	Y N

Are you currently experiencing any of the following symptoms?

Falls	Y N	Dizziness	Y N
Night Pain	Y N	Changes in Vision	Y N
Fever / Chills / Night Sweats	Y N	Frequent Headaches	Y N
Unexplained Weight Loss	Y N	Shortness of Breath	Y N
Anxiety / Depression	Y N	Bowel or Bladder Changes	Y N
Pregnant? If yes, which trimester __	Y N	Other: _____	

Do you take blood thinners? **Y N**
Do you have any known diseases that can be transmitted through bodily fluids? **Y N**
Have you had surgery in the last 12 weeks? **Y N**
Do you have any implants? **Y N**

Are you currently receiving home health services? **Y N**

Patient Signature:_____**Date**:_____