MANGIARELLI REHABILITATION
8935 E. MARKET ST. WARREN, OHIO 44484
Ph.: 330-393-0079 Fax: 330-393-0005

PAST MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ Date of Birth: _____
Reason for Therapy _____ Date of Onset _____
Have you ever received therapy for the condition mentioned above? Yes No
If so when_____ Previous treatment: Successful Unsuccessful
Could you be pregnant Yes No * **Ht:** _____ * **Wt:** _____

Do you NOW or have you EVER had any of the following?

Condition	Yes	No	Condition	Yes	No
Arthritis	Y	N	Diabetes	Y	N
Osteoporosis	Y	N	Anemia	Y	N
High Blood Pressure	Y	N	Hypersensitivity hot/cold	Y	N
Heart Disease	Y	N	Swelling in Ankles	Y	N
Heart Attack	Y	N	Deep Vein Thrombosis	Y	N
Pacemaker	Y	N	Seizures/Epilepsy	Y	N
Vascular Disease	Y	N	Metal in body/implants	Y	N
Stroke	Y	N	Cancer/Tumor	Y	N
Asthma	Y	N	Recent Weight loss/gain	Y	N
Shortness of breath	Y	N	Current Infection	Y	N
Chronic Cough	Y	N	Tuberculosis	Y	N
Fainting Spells	Y	N	Hepatitis	Y	N
Thyroid Problems	Y	N	Headaches	Y	N
Head Injury/Concussion	Y	N	Hernia	Y	N
Kidney/Bladder problems	Y	N	Previous Fractures	Y	N
Previous Surgeries	Y	N	Hearing Loss	Y	N
Hearing Loss	Y	N	Depression	Y	N
Anxiety	Y	N	Substance Abuse	Y	N

If you answered "Yes" on any of the above, please explain and give approximate date(s):

_____

_____

Do you have any allergies? Yes No If yes, list _____

Are you presently taking any medications? Yes No If yes, list _____

_____

The information is correct to the best of my knowledge

How did you hear about our office: WEBSITE_____PHONE BOOK_____ OTHER _____

Patient/Parent/Guardian Signature: _____ Date: _____