Burkhardt
Physical Therapy Center

1555 Heritage Blvd.
West Salem, WI 54669

Phone: (608)786-4989 Fax: (608)786-2321 Web: Burkhardtpt.com

Past and Recent Medical History

Patient Name: _____ Date: _____

Have you ever been diagnosed with or had any of the following:

___ Headaches or migraines
___ Stroke If yes, Year_____
___ Seizures/Epilepsy
___ Digestive Disorder
___ Kidney Disease
___ Liver Disease
___ Diabetes
___ Thyroid Disease
___ High Blood Pressure If yes, is it medication controlled? ___Yes ___No
___ Blood Clots Are you on blood thinners? ___Yes ___No
___ Heart Attack If yes, Year _____
Defibrillator ___Yes ___No Pacemaker ___Yes ___No
___ Cancer Type: _____
___ Chronic Fatigue Syndrome
___ Fibromyalgia
___ Anxiety
___ Depression
___ Arthritis Where: _____
___ Osteoporosis
___ Gout
___ Vertigo
___ Currently Pregnant Due Date: _____

List any surgeries and year if known: _____
_____

Is there anything else the therapist should know about your medical history?
_____
_____

Please list any allergies: _____

I hereby certify that the above information is true and correct to the best of my knowledge.
Patient Signature:_____ Date: _____

Medical Professional reviewed: _____(Therapist Signature) Date:_____

Updated 12/16 BO