Mankato Clinic

EXTERNAL OCCUPATIONAL THERAPY QUESTIONNAIRE

Social history

Do you smoke? Y N **Do you drink alcohol?** Y N **Do you use drugs or medications recreationally?** Y N

Do you have a history of falls? Y N **How many?** _____ **Were you injured?** Y N **What caused the fall?** _____

Do you exercise? Y N **How often?** _____

Current and past medical history: (Check all that apply)

	Y	N	Family		Y	N	Family		Y	N	Family
Anemia/Blood Disorder				**Angina**				**Anxiety/Panic Disorder**			
Arthritis				**Asthma**				**Congestive Heart Failure**			
COPD/Emphysema				**Depression**				**Diabetes I or II**			
Dizziness				**Epilepsy**				**Fibromyalgia**			
GERD/Reflux/Gallbladder				**Hearing Impairment**				**Heart Attack**			
Heart Disease				**Hepatitis/AIDS**				**High Blood Pressure**			
Incontinence				**Kidney/Bladder Problems**				**Multiple Sclerosis**			
Osteoporosis				**Pacemaker**				**Parkinson's Disease**			
Peripheral Vascular Disease				**Prostate/Urinary Problems**				**Prosthesis/Implants**			
Sleep Dysfunction				**Stroke or TIA**				**Thyroid**			
Tuberculosis				**Vertigo**				**Visual Impairment**			

History of cancer (circle) Y N Family **If yes, what type**_____

Are you currently pregnant? Y N

Do you have any allergies? Y N **If yes, please list**: _____

Past surgical history (please list all surgeries and dates):

_____

_____

In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications. Please list all prescriptions, over-the-counter medications, vitamins, herbs, dietary supplements and homeopathic remedies. If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.

Medication Name (brand or generic)	Dose	Frequency	Purpose	Medication route
Example: Zantac	*150 mg*	*Once daily*	*Heart burn*	*By mouth*

The above health information is correct to the best of my knowledge:

Patient/guardian signature: _____**Date:**_____

I certify that the above health information has been reviewed with patient:

Therapist signature: _____**Date:** _____