PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

MEDICAL HISTORY

Allergies	O Yes O No	Depression	O Yes O No	Multiple Sclerosis	O Yes O No
Anemia	O Yes O No	Diabetes	O Yes O No	Osteoporosis	O Yes O No
Anxiety	O Yes O No	Dizzy Spells	O Yes O No	Parkinsons	O Yes O No
Arthritis	O Yes O No	Emphysema/Bronchitis	O Yes O No	Rheumatoid Arthritis	O Yes O No
Asthma	O Yes O No	Fractures	O Yes O No	Seizures	O Yes O No
Cancer	O Yes O No	Gallbladder Problems	O Yes O No	Speech Problems	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Strokes	O Yes O No
Cardiac Pacemaker	O Yes O No	High Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Chemical Dependency	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Circulation Problems	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Currently Pregnant	O Yes O No	Metal Implants	O Yes O No		

Describe any other conditions or precautions:

Falls History

Injury as a result of a fall in the past year? O Yes O No Date of Fall:_____
Two or more falls in the last year? O Yes O No Dates of Falls:_____

Surgical History

Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____

Current Medications

Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
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