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

MEDICAL HISTORY

WHEN IS YOUR NEXT VISIT WITH YOUR DR? _____

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	Strokes	O Yes	O No
Cardiac Conditions	O Yes	O No	Hepatitis	O Yes	O No	Thyroid Disease	O Yes	O No
Cardiac Pacemaker	O Yes	O No	High Blood Pressure	O Yes	O No	Tuberculosis	O Yes	O No
Chemical Dependency	O Yes	O No	Incontinence	O Yes	O No	Vision Problems	O Yes	O No
Circulation Problems	O Yes	O No	Kidney Problems	O Yes	O No			
Currently Pregnant	O Yes	O No	Metal Implants	O Yes	O No			

Describe any other conditions or precautions:

Fall 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:_____

Drug: _____ Dosage: _____ Reason for Taking:_____