Medical History

Name: D.O.B.

Existing or Relevant Previous Conditions

		Start Date	End Date			Start Date	End Date			Start Date	End Date
Allergies	◯Yes◯No			Dizzy Spells	◯Yes◯No			MRSA	◯Yes◯No		
Anemia	◯Yes◯No			Emphysema/Bronchitis	◯Yes◯No			Multiple Sclerosis	◯Yes◯No		
Anxiety	◯Yes◯No			Fibromyalgia	◯Yes◯No			Muscular Disease	◯Yes◯No		
Arthritis	◯Yes◯No			Fractures	◯Yes◯No			Osteoporosis	◯Yes◯No		
Asthma	◯Yes◯No			Gallbladder Problems	◯Yes◯No			Parkinsons	◯Yes◯No		
Autoimmune Disorder	◯Yes◯No			Headaches	◯Yes◯No			Rheumatoid Arthritis	◯Yes◯No		
Cancer	◯Yes◯No			Hearing Impairment	◯Yes◯No			Seizures	◯Yes◯No		
Cardiac Conditions	◯Yes◯No			Hepatitis	◯Yes◯No			Smoking	◯Yes◯No		
Cardiac Pacemaker	◯Yes◯No			High Cholesterol	◯Yes◯No			Speech Problems	◯Yes◯No		
Chemical Dependency	◯Yes◯No			High/Low blood pressure	◯Yes◯No			Strokes	◯Yes◯No		
Circulation Problems	◯Yes◯No			HIV/AIDS	◯Yes◯No			Thyroid Disease	◯Yes◯No		
Currently Pregnant	◯Yes◯No			Incontinence	◯Yes◯No			Tuberculosis	◯Yes◯No		
Depression	◯Yes◯No			Kidney Problems	◯Yes◯No			Vision Problems	◯Yes◯No		
Diabetes	◯Yes◯No			Metal Implants	◯Yes◯No						

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Medical Precautions

Fall History

Injury as a result of a fall in the past year? ◯Yes◯No

Two or more falls in the last year? ◯Yes◯No

Patient at risk for falls? ◯Yes◯No

Hand Dominance ◯Right◯Left

Surgical History

Medical History

Name: D.O.B.

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

- **Currently not taking any medications**