Medical History **Name:**______________________________**DOB:**____/____/_______

Existing or Relevant Previous Conditions Please Circle One

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	Parkinson's	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.

Fall History Please Circle One

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

Body Region:______________Surgery Type:____________________Date:____/____/_____

Body Region:______________Surgery Type:____________________Date:____/____/_____

Body Region:______________Surgery Type:____________________Date:____/____/_____

Current Medications

Drug:____________________Dosage:_____Frequency:__________Reason Taking:_________

Drug:____________________Dosage:_____Frequency:__________Reason Taking:_________

Drug:____________________Dosage:_____Frequency:__________Reason Taking:_________

Drug:____________________Dosage:_____Frequency:__________Reason Taking:_________

☐ Currently not taking any medications