**Medical History** Name: D.O.B.

# Existing or Relevant Previous Conditions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 | Smoker  g | ⃝ 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 Therapy History

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Injury as a result of a fall in the past year? ⃝ Yes ⃝ No Have you been seen by a physical, occupational, or

speech therapist in the past 60 days? ⃝ 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: , ,

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**