

Medical History

Patient Name: _____

DOB: _____

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	MRSA	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	High/Low blood pressure	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Covid-19	<input type="radio"/> Yes <input type="radio"/> No	HIV/ AIDS	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No

Existing or Relevant Previous Conditions

Weight _____ lbs Height _____ ft _____ in

Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates/ describe any other conditions.

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

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: _____

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Currently not taking any medications

Medications scanned in chart