PATIENT MEDICAL HISTORY

Name:_____ **Date:**_____

Do you have problems with your: ☐ **eyesight** ☐ **hearing** ☐ **ability to read** ☐ **ability to write**

Check if <u>you</u> have or have had any of the following:

☐ **pace maker**	☐ **lung disease**	☐ **cancer**
☐ **blood thinners**	☐ **arthritis**	☐ **broken bones (fractures)**
☐ **high blood pressure**	☐ **joint replacements**	☐ **osteoporosis**
☐ **high cholesterol**	☐ **diabetes**	☐ **stroke**
☐ **heart disease**	☐ **migraine headaches**	☐ **kidney disease**
☐ **chest pain**	☐ **epilepsy/seizures**	☐ **liver disease**

☐ **blood relative under 55 who suffered a stroke or heart attack**

Have you fallen 2 or more times in the last year OR have you fallen one time resulting in injury? Y / N

List any *recent* (within last year) hospitalizations / reasons / dates: _____
_____
_____

List any *recent* surgeries and dates:_____
_____
_____

MEDICATIONS AND SUPPLEMENTS (please complete or provide a separate list if not enough space)

	NAME	REASON (Pain, BP, Diabetes etc)	How Much (Mg)	How Often (per day or wk)	How Taken (mouth, inject)
Prescription Meds					
Over the counter Meds					
Supplement (vitamins)					

<u>Medications</u> I am allergic to: _____
Food and other things I am allergic to:_____

Women: Is there a chance you may be pregnant? ☐ **Yes** ☐ **No**

I have completed and updated my information:

DATE	INITIALS	PT Initials

My height and weight

Height	Weight	BMI (PT use only)