

PATIENT MEDICAL HISTORY

Name: _____

Date: _____

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

Check if **YOU** have or have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> pace maker | <input type="checkbox"/> lung disease | <input type="checkbox"/> cancer |
| <input type="checkbox"/> blood thinners | <input type="checkbox"/> arthritis | <input type="checkbox"/> broken bones (fractures) |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> joint replacements | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> migraine headaches | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> 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)					

Medications 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)

