PATIENT MEDICAL HISTORY

PATIENT FULL NAME (LAST, FIRST, MI)	DOB: (MM/DD/YYYY)

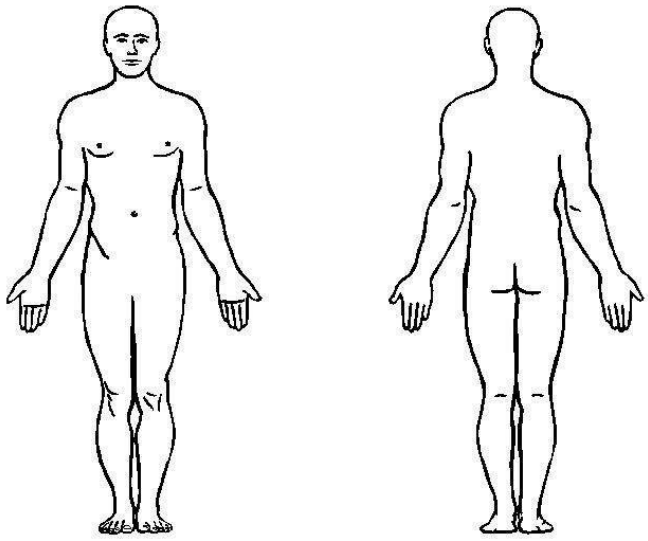
Have you sustained injury as a result of a fall in the past year? YES NO

Have you sustained two or more falls in the past year? YES NO

HAVE YOU EVER, OR ARE YOUR PRESENTLY BEING TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

Allergies	Y	N	High/Low Blood Pressure	Y	N
Anemia	Y	N	High Cholesterol	Y	N
Anxiety	Y	N	HIV/AIDS	Y	N
Arthritis	Y	N	Incontinence	Y	N
Asthma	Y	N	Kidney Problems	Y	N
Autoimmune Disorder	Y	N	Metal Implants	Y	N
Cancer	Y	N	MRSA	Y	N
Cardiac Conditions	Y	N	Multiple Sclerosis	Y	N
Cardiac Pacemaker	Y	N	Muscular Disease	Y	N
Chemical Dependency	Y	N	Osteoporosis	Y	N
Circulation Problems	Y	N	Parkinson's Disease	Y	N
Depression	Y	N	Currently Pregnant	Y	N
Diabetes (type 1 or 2)	Y	N	Rheumatoid Arthritis	Y	N
Dizzy Spells	Y	N	Seizures	Y	N
Emphysema/Bronchitis	Y	N	Smoking	Y	N
Fibromyalgia	Y	N	Speech Problems	Y	N
Fractures	Y	N	Strokes	Y	N
Gallbladder Problems	Y	N	Thyroid Disease	Y	N
Headaches	Y	N	Tuberculosis	Y	N
Hearing Impairment	Y	N	Vision Problems	Y	N
Hepatitis	Y	N			

Circle problem area:



Surgical History

Body Region	Surgery Type	Date of Surgery
Body Region	Surgery Type	Date of Surgery
Body Region	Surgery Type	Date of Surgery
Body Region	Surgery Type	Date of Surgery

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 _____ Medications scanned on a separate list _____