

## Medical History

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### Existing Conditions

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	Parkinsons	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<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	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<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
Circulation Problems	<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
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		

### Describe any other conditions or precautions

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## Fall History

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Injury as a result of a fall in the past year?  Yes  No

Two or more falls in the past year?  Yes  No

## Surgical History

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Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

## Current Medications

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Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_