# PAST MEDICAL HISTORY

## Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IS THIS INJURY A RESULT OF A CAR ACCIDENT OR WORK INJURY? YES NO**

**HEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle if you have any of these conditions.**

Diabetes Heart Disease Angina/Chest Pain

Stroke High Blood Pressure Seizures

Metal Implants Osteoarthritis Osteoporosis

Rheumatoid Arthritis Headaches Migraines

Depression/Anxiety Lung Disease/COPD Liver Disease

Fibromyalgia Allergies/Asthma Peripheral Neuropathy

Fear of falling Pacemaker HIV/AIDS

Latex Sensitivity Urinary Incontinence Multiple Sclerosis

Circulation Problems Hepatitis Tuberculosis

High Cholesterol Thyroid Problem Kidney Disease

* **Have you had any falls this past year? Yes No**
* **Have you had an injury from your fall? Yes No**
* **Please describe injuries from fall\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you pregnant?.............................................................. □ yes □no

Are you dizzy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_yes \_\_no

Are you unsteady?……………………………………….. ‪□ yes ‪□ no

Have you had any recent falls?………………………….. ‪ □ yes □‪ no

Have you experienced any change in your hearing?……. ‪□ yes □‪ no

If yes, has it been …………………………………. □ recent □‪ gradual

If yes, have you seen an ENT?.................................. □ yes □‪ no

Have you experienced any visual changes?……………. □ yes □‪ no

Do you smoke?…………………………………………. ‪ □ yes ‪ □ no

Do you take any blood thinners?……………………….. □ yes □ ‪no

Have you had significant weight change?......................... □ yes ‪ □ no

During the past month have you felt down, depressed, or had little interest in doing

things? **Yes No**

Do you ever feel unsafe at home or has anyone tried to hurt you in any way? **Yes No**

Do you drink alcohol? **Yes No**

If yes, how many days per week do you drink? \_\_\_\_

Cancer (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other Illness (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recent Hospitalization** (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History** (please explain):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list medications, vitamins, herbal supplements, and over the counter medications you are taking.**

**Medication Name Dosage Frequency How is it taken**

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**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please provide an emergency contact for us:***

Name: PERMISSION TO SPEAK TO THIS PERSON REGARDING YOUR CARE \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO WE HAVE YOUR PERMISSION TO SPEAK TO THIS PERSON REGARDING YOUR CARE\_\_\_\_\_\_\_\_