# VFT LOGO

**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.**

Allergies / Asthma High Cholesterol Osteoarthritis

Angina / Chest Pain HIV / AIDS Osteoporosis

Anxiety / Depression Kidney Disease Pacemaker

Diabetes Latex Sensitivity Peripheral Neuropathy

Fibromyalgia Liver Disease Seizures

Headaches / Migraines Lung Disease / COPD Stroke/TIA

Heart Disease Metal Implants Thyroid problem

High Blood Pressure Multiple Sclerosis Urinary Incontinence

Parkinson’s Disease

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

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

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

* 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

Do you drink alcohol? **Yes No**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Over the past 2 weeks***, how often have you been bothered by any of the following problems? Check the box that corresponds most closely to what you feel. | | | | |
| 1. Little pleasure or interest in doing things? | Not at all | Several Days | More than ½ the Days | Nearly Every Day |
| 2. Feeling down, depressed, or hopeless? | Not at all | Several Days | More than ½ the Days | Nearly Every Day  *from Patient Health Questionnaire-2 (PHQ-2)* |

***Within the last 12 months...***

Have you ever relied on people for any of the following: bathing, dressing,

shopping, banking, or meals? ---------------------------------------------------------------- Yes No

Has anyone prevented you from getting food, clothes, medication, glasses, hearing

aides, or medical care or from being with people you wanted to be with you? ---- Yes No

Have you been upset because someone talked to you in a way that made you feel

ashamed or threatened? --------------------------------------------------------------------- Yes No

Has anyone tried to force you to sign papers or to use your money against

your will? ---------------------------------------------------------------------------------------- Yes No

Has anyone made you afraid, touched you in ways that you did not want or hurt you

physically? -------------------------------------------------------------------------- ----------- Yes No

*from The Elderly Abuse Suspicion Index (EASI)*

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

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

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

**Please list medications: (OR include pre-fabricated list)**

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

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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